Self-Reported Experiences in Family Therapy of Lower-Income Black Adolescents in a Residential Treatment Facility: A Phenomenological Study

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Dedications

This dissertation is dedicated to all those special individuals, who have pushed me to work hard, day in and out, in making this dream a reality:

To the RTF participants, who willingly devoted their time to take part in this research study. To the three Black RTF youth who lost their lives in 2016, as a result of community violence. To Black youth and their families, who are victimized daily, solely on the basis of their social locations in marginalized groups. To single mothers who courageously raise their children with limited supports.

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Abstract

Self-Reported Experiences in Family Therapy of Lower-Income Black Adolescents in a Residential Treatment Facility: A Phenomenological Study
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Residential treatment facilities (RTFs) have become a significant intervention within the system of care (SOC) spectrum. RTFs provide a broad array of mental health services to youth and families experiencing severe behavioral, emotional and/or psychological problems. Through in-depth semi-structured interviews, this transcendental phenomenological study examined the experiences of lower-income Black adolescents in family therapy in a RTF, located in a large urban Northeastern city of Philadelphia. A sample of 15 Black male and female RTF residents, aged 15 and 16, participated in this study.

The analysis of the data was guided by the frameworks of Narrative and Africana womanism theories, as well as the multicultural perspective (MCP). The study categorized its findings in 6 general themes and 24 subthemes. The general themes included: *(1) views on receiving family therapy in the RTF; (2) therapeutic alliance and relationship with RTF therapist; (3) developmental and cognitive shifts in self; (4) treatment goals in family therapy in the RTF; (5) views on racial inequalities and injustices; and (6) experiences with trauma and loss.*

Overall, most participants found family therapy in the RTF to be helpful. The data also suggested that although most participants' narratives included the salience of race, race was an under-discussed topic in therapy. Conversely, far fewer participants situated their experiences in the context of age or gender. Finally, class was only mentioned vaguely, if at all. It remained unclear whether participants understood the concept of

social class, as inconsistent self-identification of social class was common among the sample. All in all, the study clearly demonstrated that familial involvement in RTF therapy for Black adolescents was helpful in achieving successful therapeutic outcomes across a range of mental health diagnoses.

CHAPTER 1: INTRODUCTION

1.1 Overview of Chapter

Residential treatment facilities (RTFs) were originally intended to treat youth with behavioral, emotional and/or psychiatric disorders. They were first instituted to treat primarily males, employing a "boot camp" model to correct disruptive or violent behaviors (MacKenzie, Stybe, & Gover, 2004). As a result of demographic shifts, which included an increase in the admission of female youth, the boot camp model began to recede. Additionally, an increase in the admission rates of Black and Hispanic youth was noted with the RTF population prompting a re-evaluation of whether RTF treatment protocols were appropriately "culturally competent."

The role that families play in RTF treatment was critical to its re-evaluation. While previously viewed as inimical to effective therapeutic outcomes, it is now widely accepted that family involvement is essential to the formulation of successful transition plans, and for a seamless, durable re-integration into familial and community life once treatment has concluded. A multitude of family-centered models have been proposed, all of which aim to effectively manage the treatment of minority RTF youth with complex family dynamics.

Unfortunately, the above-described changes in the needs of the adolescent RTF population and the system's attempt to meet them have been understudied. More specifically, there is insufficient research into how racial minorities experience family therapy in a RTF setting, and whether factors such as race, gender, class and age are salient in those experiences. Through the use of a transcendental phenomenological approach, this study explored the experiences of lower-income Black adolescents in family therapy in a RTF. This study included 15 participants, 15 or 16 year old males and

females, who self-identified as Black and African-American. Participants' interview responses are categorized and the resultant data was analyzed to better understand their experiences through a socio-cultural lens.

Three theories (frameworks) were applied for data analysis. First, Narrative theory assists in determining how a person "stories" his/her world, uncovering the meaning of the story and helping him/her reauthor an alternative, more positive, helpful story (White & Epston, 1990). Second, Africana womanism theory helps to explore the intersectionality of race, class and gender that often manifests in adolescent mental health (Hudson-Weems, 1998). Finally, the multicultural perspective (MCP) allows a person's experiences to be understood through a socio-cultural lens. Stated succinctly, it is a philosophical posture that influences how individuals see the world, see others in the world, and most importantly, how they see themselves in the world (Hardy & Laszloffy, 1995).

1.2 Statement of the Problem

Residential care's rise to prominence in the 1940s is widely attributed to the escalating need to provide mental health treatment to the growing number of youth experiencing behavioral, emotional and/or psychiatric problems (Liechtman, 2006). Because the disorders encountered vary greatly, the forms of residential care also vary, so that services rendered in a given facility can meet the individual needs of the residents being treated. RTFs are a type of residential care facility that provide clinical therapies and pharmacological services that are critical for the successful recovery of those diagnosed with severe behavioral, emotional, and/or psychiatric disorders. As a result of shifts in state policies, familial involvement came to be considered a vital element of

successful residential recovery programs; thus, facilities began to adjust their treatment protocols to accommodate families (Behan & Brodgett, 2003). Today, the clinical services provided by therapists in RTFs include individual, family and group therapies, in addition to consultations with child and adolescent psychiatrists for medication management.

Historically, RTFs have served as "boot-camps," offering military-style residential treatment that catered to the needs of troubled youth, mainly males, with disruptive behavior disorders (Handwerk et al., 2006; MacKenzie, et al., 2004). These boot camps were designed to correct disruptive behaviors in youth who presented with behavioral and emotional self-regulation difficulties. These residents had histories of failure in traditional academic settings, in family relationships and in peer-to-peer interactions (Weis, Whitemarsh, & Wilson, 2005). The broad applicability of the "boot camp" model eventually came under scrutiny. Critics contended that because boot camps were originally designed for incarcerated antisocial men, they did not appropriately and effectively target the problems of adolescents (Handwerk et al., 2006; MacKenzie et al., 2004).

An examination of the relevant literature on the subject of contemporary mental health issues supports the position of the boot camp critics. Today, adolescent male and female RTF residents demonstrate challenges in their daily lives; however, there are some differences. Both groups often present with hyperactivity, impulsivity and learning difficulties, although females tend to display acts of covert aggression in interpersonal context while males typically do not (Moffit, Caspi, Rutter, & Silva, 2001). Females who exhibit disruptive behaviors may also be at elevated risk for internalizing problems such

as anxiety, depression and suicide (Acoca, 1999; Bureau of Justice Statistics, 2001; Thomas, Temple, Perez, & Rupp, 2011; Weis et al., 2005). In addition, there is ample and convincing evidence that childhood physical abuse is a risk factor for antisocial behaviors in adolescents. The rates of physical abuse among adolescent females are higher than those for males (Wekerle & Wolfe, 2003). As many as two-thirds of female RTF residents have experienced some form of sexual abuse (Connor et al., 2004). With an increased emphasis on these issues, the prevalence of the boot camp model of behavioral modification began to recede.

As youth involved in the social service and juvenile justice systems began to increasingly be referred to RTFs, the population characteristics of the RTF underwent a noticeable change. There has been a marked increase in the prevalence of Black and Hispanics youth in RTFs (Warner & Pottick, 2003). Likewise, the female adolescent RTF population has increased disproportionately (Weis et al., 2005). A dramatic rise in the diagnosis of antisocial behaviors among adolescent females is thought to be the cause of this increase. All in all, these demographic changes justify the need for a re-examination of the adolescent RTF population, with a microscopic lens on the variables of race and gender (Acoca, 1999; Bureau of Justice Statistics, 2003; Synder, 2003).

Overall, the needs of the adolescent RTF population are unique in many ways. Adolescent RTF residents come from complex family backgrounds, with extensive histories of trauma, abuse and neglect, along with high rates of recidivism (Warner & Pittick, 2003). As noted, the demographics of the residential population have changed drastically with an increased number of Blacks and females being admitted. The rehabilitation system of care (SOC) that is intended to provide various services to these

residents is often fragmented, ineffective and lacking collaboration, partly due to a widespread ignorance of the cultural idiosyncrasies of minority familial units (Bloom & Farragher, 2013; Cooper et al., 2008; Winters & Pumareiga, 2007).

Thus, it is imperative that researchers and clinicians redouble their efforts in identifying the shortcomings of these systems, as they pertain specifically to the minority RTF residents and their families. A renewed examination of these systems may provide insight into what changes need to be made so that future treatment protocols are more effective. It may also pave the way for more culturally competent RTF clinical services. This study is intended to lay the foundation for a newly focused understanding of the experiences of Black adolescents in family therapy in a RTF. The findings of this study explored the nuances of these experiences, along with highlighting implications for both future clinical work and research with this population.

1.3 The Phenomenon in Broader Social Context

As the fields of child psychiatry and social work evolved and became well-respected, they necessitated the development of residential treatment programs to treat mental illness in youth (Magellan Health Services, 2008). The evolution of residential care is a direct result of the need to provide services and purposeful mental healing to abused and neglected youth, by placing them in a safe, structured residential environment (Magellan Health Services, 2008). “Residential treatment” is defined as an institutional setting that is typically operated by psychologists and social workers, who provide fewer and less sophisticated therapies, while receiving much lower reimbursement than inpatient psychiatric treatment (Leichtman, 2006; Magellan Health Services, 2008).

The growth in residential treatment has been accompanied by decreased access to inpatient hospitalization. RTFs increasingly serve as an alternative to inpatient psychiatric care for many seriously emotionally disturbed youth (Connor et al., 2004). The unavailability of sufficient home and community-based programs, financial incentives and reduced use of inpatient psychiatric treatment all contributed to the increased use of RTFs (Allen & Brown, 2010). RTFs offer youth services similar to inpatient hospitalization, including a clinical team with physicians, case managers, clinical social workers and/or therapists, all oriented towards treating youth from complex backgrounds. These services are vital to RTF youth who usually struggle in their social environments, to include family, school and the community.

Despite a recent national movement towards non-residential or community-based mental health treatment of seriously emotionally disturbed youth, the number of youth admitted to residential treatment programs has increased significantly since 1980 (Connor, Doerfler, Toscano, Volungis, & Steingard, 2004). Statistics show that by the 1980s, 125,000 youth were being treated in RTFs. By the year 2000, the number of youth being treated had significantly increased to a quarter million (Butler & McPherson, 2007; Magellan Health Services, 2008). An estimated 657,000 youth aged 12 to 17 years received residential mental health treatment between 2002 and 2006 (Substance Abuse and Mental Health Services Administration, 2008). Specifically, in the year 2003, 65,949 youth were in residential care, of which 42,015 were reported to be in RTFs as opposed to other out-of-home care (Warner & Pottick, 2003). In addition, approximately 8% of youth with mental health needs utilize residential care and 25% of the funding is spent for this service (Butler and McPherson, 2006). Nationally, the number of residential

treatment centers for emotionally disturbed youth has risen from 13,489 in 1969 to 35,709 in 2002 (Center for Mental Health Services, 2004).

With reference to the Census of Juveniles in Residential Placement (CJRP) survey, the National Center for Education Statistics (NCES) found gender and racial disparities in juvenile residential placement, disparities that were durable and persisted over time. While the rates for both males and females declined significantly from 1997-2013, there remained 6 times as many males as females in residence (NCES, 2016). Similarly, the rates for all racial/ethnic groups – white, Black, Hispanic and American Indian/Alaska Native and Asian/Pacific Islander – declined between 1997 and 2013. Despite this decrease, there were clear racial differences. For example, in 1997 Black youth were 4.8 times more likely to be placed than white youth. Similarly in 2013, Blacks were 4.6 times more likely to be placed. The placement rates for Hispanic versus white youth were 2.3 in 1997 and 1.7 in 2013 (NCES, 2016). Furthermore, in 2013, Black males made up over one-third of all youth residential placements, 5 times the rate of white males and 2.7 times the rate of Hispanic males (NCES, 2016). Black female residential placement rates exceeded rates for all other female groups except American Indian/Alaska Native (NCES, 2016). This data clearly demonstrates the existence and persistence of racial and gender disparities in youth residential placement.

1.3.1 Systems of Care

In 1985, funding from the National Institute of Mental Health's (NIMH) Child and Adolescent Service System Program (CASSP) initiative provided an opportunity for states to examine the needs of youth and families from a mental health practice perspective (Behan & Blodgett, 2003; Lindblad-Goldberg, Jones, & Dore, 2004; Winters

& Pumariega, 2007). The main question that mental health consumers and providers throughout the state asked was: *do services need to be modified or adapted to meet the special needs of youth and their families?* (Lindblad-Goldberg et al., 2004). The result was the resolution to modify and adapt services for both families and youth, to help facilities better cope with the special needs of the residential youth population (Chenven, 2010; Lindblad-Goldberg et al., 2004).

This shift from individual-guided to family-driven treatment was based on the premise that mental health care should: (1) be tailored to the individual needs of the youth, (2) be strength-based, and (3) involve the family in *all* aspects of service delivery, from implementation to evaluation (Behan & Blodgett, 2003; Wald et al., 2014). Strict emphasis was placed on strong extended family involvement and upbringings of the youth, as well as incorporating natural community resources to address the emotional, psychological, and physical needs of all family members.

To effectuate its vision, CASSP assisted states and communities in building the capacity to develop a *system of care (SOC)spectrum* to target youth with serious and complex needs (Behan & Blodgett, 2003; Stroul & Manteuffel, 2007; Winters & Pumariega, 2007). A SOC was defined as "a comprehensive spectrum of mental health and other necessary services and supports which are organized into a coordinated network to meet the multiple and changing needs of youth with serious emotional disturbances and their families" (Stroul & Manteuffel, 2007, p. 238). The SOC model was developed to address the needs of youth with serious (or severe) emotional disturbance (SED). It stipulated that youth with SED have a diagnosable mental, behavioral and/or emotional disorder that has resulted in impairments that interfered or

limited the child's ability to function at home, in school and/or community (Winters & Pumareigo, 2007). It was recommended that services be coordinated on different levels and in different settings, which include six service components highlighted in the SOC model. These components include: (1) mental health, (2) primary health care, (3) education, (4) child welfare, (5) juvenile justice, and (6) developmental disabilities (Cooper, Aratani, Knitzer, Douglas-Hall, Masi, Banghart, & Dababnah, 2008; Winters & Pumareigo, 2007).

RTFs lie on this SOC spectrum, which ranges from least-restrictive (outpatient) to most-restrictive (inpatient hospitalization). RTFs continue to serve as one of the highest, most-restrictive levels of care; therefore they are utilized as the last resort for youth who present with complex behavioral, emotional, and/or psychiatric challenges. RTFs are utilized and recommended when other least-restrictive services in the community, such as wraparound, family-based, therapeutic foster care and partial day programs, have been exhausted (Cooper et al., 2008; Wald, Zubritsky, & Jaquette, 2014; Winters & Pumareigo, 2007).

1.3.2 Family-Centered Treatment

Adolescents residing in RTFs come from complex family backgrounds, with extensive histories of trauma, abuse and neglect, which all appear to be interrelated (Warner & Pottick, 2003). To target these issues aggressively, treatment in RTFs moved away from an individualized model to a family-centered (family-driven) model of treatment (Wald et al., 2014). For services being provided in RTFs, the CASSP principles changed how families were viewed and involved in the treatment process by developing a *system of care concept* (Behan & Blodgett, 2003). Historically, youth who were abused,

neglected and/or “out of control” were removed from their families and placed in residential care. Unfortunately, at that time residential care provided parental surrogacy due to the perception that parents were the cause of the youth’s mental health and social development problems (Harr et al., 2011). Families were regarded as ill-equipped to provide a healthy environment for their children and were blamed for the youths’ problems, which contributed to the youth being removed from the care of loved ones. As a result, it was often determined that family members should have limited involvement in the development of the plan of care (Behan & Blodgett, 2003; Harr et al., 2011).

As the field of mental health advanced, the significance of involving families in the treatment of youth was finally recognized and emphasized. Research began to show that familial support was a *protective* factor for some of the morbidities associated with emotional disturbances in minority populations (Pumareiga, 2007; Pumareiga, Swanson, Holzer, Linsky, & Quintero-Salinas, 1992; Pumariega et al., 1997). Protective factors are defined as conditions or attributes that help individuals, families and communities effectively deal with stressful events (Pumareiga et al., 1992; Pumareiga et al., 1997; Simmel, 2007). These protective factors can include strengths, resources, coping strategies and/or supports that decrease the occurrences of a negative health outcome (Simmel, 2007).

More so, youth receiving treatment were being returned home to their families without appropriate transitional and discharge plans. As these youth received treatment in RTFs, their families continued to struggle with the same hardships that led to the placement of the youth in the first place. Initially, these families were not involved in the therapeutic process and were not provided additional supports that were needed to make

significant changes in the home. This lack of involvement in the treatment process and limited access to resources hindered the clinical and behavioral progress of youth in the residential program. Thus, the American Association of Children's Residential Center (AACRC) recognized the necessity of actively involving the family in the intervention process, in addition to placing emphasis on developing programs that focus on family-driven care for youth that builds on family strengths (Harr et al., 2011).

These systemic changes created an opportunity for families to be included in treatment. Specifically for RTFs, family therapy became a vital part of the therapeutic process, as it pertained to achieving treatment goals that were focused on individual and relational growth. Family therapy held a great significance in the treatment process for youth in RTFs as majority of the youth in RTFs had a history of relational trauma, both familial and community (Cohen, Berliner, & Mannarino, 2010; Igelman, Ryan, Gilbert, Bashant, & North, 2008). Many youth were taken away from their biological parents by the child welfare system and placed in the foster care system and/or with other family members (Behan & Blodgett, 2003; Harr et al., 2011).

Several models of family therapy have been developed to meet the mental health needs of adolescents. These family therapy models include: multidimensional family therapy (MDFT); brief strategic family therapy (BSFT); and attachment-based family therapy (ABFT; Diamond, 2007; Liddle, 1985; Szapocznik, 1975). These models have shown effectiveness in reducing the specific mental health challenges that adolescents experience today. MDFT and BSFT have focused on Hispanic youth and families in the problem areas of adolescent substance abuse and delinquency as it relates to family functioning. ABFT has focused on suicidal ideations and depression in the context of

parent-child attachment. ABFT has also been tested with Black adolescents and their families. These models have been implemented in various settings, such as outpatient clinics and community settings (homes and schools).

Despite these efforts in developing empirically-supported family therapy models to serve minority youth, the adolescent population receiving RTF level of care (LOC) has been repeatedly ignored. Previous studies conducted with the RTF population have primarily focused on the engagement process in therapy and outcomes after discharge from residential care (Pumareiga et al., 1992; Pumariega et al., 1997). These research studies placed an emphasis on parental perspectives, rather than adolescent (youth) perspectives. Also, evidence-based family therapy models have been underutilized and /or minimally implemented in RTFs with minority groups. More so, despite the recognition that familial support is a protective factor associated with emotional-intelligence (maturity), research lacks data supporting the effectiveness of family therapy in RTFs. Therefore, not only does family therapy need to be studied closely in RTFs, research should further focus on how manualized family therapy models can be modified to provide effective treatment in RTFs.

In conclusion, limited research has taken a qualitative approach in understanding the experiences of adolescents in family therapy in RTFs. Research examining the experiences of minority youth in family therapy in RTF from a socio-cultural lens is also scarce. It is imperative that researchers and other professionals gain a deeper understanding of the experiences of the RTF population, so that treatment can incorporate culturally competent services catering to this specific population. By examining these

unique cultural perspectives, mental health providers can become more familiar with the needs of the specialized RTF population.

1.4 Narrow Scope of the Statement of Problem

Racial and ethnic minorities in the US face a social and economic environment of inequality that includes greater exposure to racism, discrimination, violence and poverty, all of which take a huge toll on their mental health (U.S. Office of the Surgeon General, 2001). For economically stressed Black youth and families, intergenerational patterns of poverty make it difficult for them to make strides in their lives. Often, poor Black youth become involved in a SOC that perpetuates patterns of poverty, incarceration, delinquency, trauma and substance abuse (Dashiff, DiMicco, Myers, & Sheppard, 2009). Ultimately, in an effort to rehabilitate youth, they are placed in RTFs in hopes that they will receive effective treatment so that they can become productive citizens of society (Bloom & Farragher, 2013). However, rarely are these SOC held accountable for the lack of progress experienced by the youth and families placed within their care (Bloom & Farragher, 2011, 2013; Hardy, 2013; Hardy & Laszloffy, 2005).

As underserved youth continue to experience devaluation, highlighted by racial and economic discrimination, they are returned to society to likely fail without the implementation of more meaningful systemic changes. For example, resources provided to family members are scarce; oftentimes, after individual and family therapy the youth goes back to the same school which offers few opportunities to grow academically. Those who operate the SOC seldom understand the complex needs of minority youth who are admitted to RTFs. As mentioned earlier, the demographics of the residential population

have changed in that treatment is increasingly being provided to underserved youth and families, and the female RTF population has increased substantially.

To effectively address the mental health needs of institutionalized Black adolescents specifically, it is imperative that service providers understand the nature of the lived experiences of these youth and families. The socio-cultural context in which these youth live their daily lives should be considered and recognized as a significant part of their treatment. It is the view of this researcher that addressing issues of racism, sexism, classism, ageism, etc., in RTF treatment may be helpful in gaining positive therapeutic results for these youth and their families. Unfortunately, the lack of knowledge in these areas only perpetuates the dominant narratives (devaluation, loss, trauma, victimization, etc.) of Black youth, narratives that often mirror their experiences in the larger society.

1.5 Aims of the Study

The main goal of this study was to describe the experiences of Black adolescents in family therapy in a RTF. The researcher aimed to gain an in-depth understanding of Black adolescents' experiences in family therapy in a RTF, while examining and highlighting those experiences in different socio-cultural contexts.

1.6 Overview of the Study

The study utilized a transcendental phenomenological approach to answer the main research question: *how do lower-income Black adolescents describe their experiences in family therapy in a RTF?* The study explored the experiences of 15 male and female participants, who met inclusion criteria for the study and were residing in a RTF in a large urban city of Philadelphia. Through in-depth, open-ended individual

interviews, the study captured how participants described their experiences in relation to their race, gender, social class and age. A qualitative phenomenological approach was most appropriate to achieve the goals of this study because it allowed for open disclosure of the meaning of the phenomenon (Flood, 2010). Furthermore, transcendental phenomenology was most suitable for the study because it primarily focused on obtaining detailed descriptions of the phenomenon experienced by the participants without proceeding to interpretations of those descriptions (Creswell, 2007; Flood, 2010; Wojnar & Swanson, 2007).

1.7 Research Questions

The primary research question that guided this study was: how do lower-income Black adolescents, aged 15 and 16, in a RTF describe their experiences in family therapy? To assist in exploring this phenomenon, the following sampling interview questions (Appendix B) were utilized:

- Describe your experiences in therapy in the RTF;
- Describe your experiences in family therapy in the RTF;
- Describe your experiences in family therapy as a female/male residing in the RTF;
- Describe your experiences in family therapy as a Black female/male residing in the RTF;
- Describe your experiences in family therapy as an adolescent female/male residing in the RTF;
- And describe your experiences as a {insert socio-economic status (SES)} female/male residing in the RTF.

The researcher developed sub-questions (Appendix B) to help participants understand the sampling research questions comprehensively so that rich, thick descriptions could be obtained about the phenomenon under investigation. It should be noted that answers to the first question were not analyzed. The first question serves the sole purpose of building rapport with the participants and creating a context for the participants to answer the research questions regarding their experiences in family therapy in the RTF.

1.8 A Phenomenological Approach

Phenomenology is a widely used qualitative approach that is considered a philosophical discipline, theoretical framework and research method (Clark, 1998; Richards & Morse, 2007; Wojnar & Swanson, 2007). The foundational question that phenomenology seeks to answer is: what is the meaning, structure and essence of the lived experience of this phenomenon for this person or group of people? (Creswell, 2007; Patton, 2002; Wojnar & Swanson, 2007). At the core of phenomenology lies the attempt to describe and understand phenomena such as caring, healing and wholeness as experienced by individuals who have lived through them (Wojnar & Swanson, 2007). To meet its goal, phenomenological data can be collected through different perspectives, which include, but are not limited to: transcendental (also called descriptive), naturalistic, existential, linguistical, hermeneutic (also called interpretive) and realistic (Creswell, 2007; Richards & Morse, 2007; Wojnar & Swanson, 2007).

For this study, the method of transcendental phenomenology was utilized to explore the phenomenon of family therapy in a RTF from the perspectives of Black adolescents. Transcendental phenomenology explores the way knowledge comes into being and how it is based on insights rather than objective characteristics (Richards &

Morse, 2007). This phenomenological approach was most appropriate for this study because it allowed participants to thoroughly provide descriptions of their lived experiences in family therapy in the RTF. Additionally, Kauffmann and Schonwald (1988) have suggested that transcendental phenomenology is more useful for inquiries that aim to discover universal aspects of a phenomenon that were never conceptualized or incompletely conceptualized in prior research (Wojnar & Swanson, 2007). For this study, a transcendental phenomenology provided Black adolescents an opportunity to describe a phenomenon that has not been previously explored thoroughly in RTFs.

1.9 Theoretical Frameworks

Narrative theory, Africana womanism theory and the multicultural perspective (MCP) were utilized as the guiding frameworks for this study. The researcher utilized these theoretical frameworks to investigate and conceptualize the experiences of Black adolescents in family therapy in a RTF. Narrative theory was developed by White and Epston (1990), who sought to create opportunities for individuals to use narratives and storytelling in family therapy (Phipps & Vorster, 2014). Narrative theory is based on the premise that "there are no events that we can comprehend objectively and … we all have stories, also defined as narratives, about these events" (Hoffman, 1993, p. 106; White & Epston, 1990). Stories consist of events that are linked in sequence, across time, while narratives are threads that weave events together to form a story (Morgan, 2000; White & Epston, 1990). Hence, the aims of narrative theory are to interpret how the individual is storying his/her world, determine what the meaning of the story is for him/her and to help him/her reauthor an alternative, more positive, helpful story (Morgan, 2000; White & Epston, 1990).

In doing so, Narrative theory encompasses four main tenets: (1*) deconstructing the dominant story, (2) externalizing the problem, (3) identifying unique outcomes, and (4) reconstructing and/or reauthoring of the story* (Carr, 1998; Morgan, 2000; Morgan, Brosi, & Brosi, 2011; White & Epston, 1990). First, deconstruction of the dominant story is achieved by discovering, acknowledging and "taking part" in the beliefs, ideas and practices of the broader culture in which a person lives, that contribute to the problem and the problem story (Morgan, 2000, p. 45; White & Epston, 1990). Narrative theory holds that problems are only sustained when they are supported by particular ideas, beliefs and principles, which make it difficult for individuals to externalize their problem(s) (Morgan, 2000; Nichols & Schwartz, 2006; White & Epston, 1990). Deconstruction simply means examining assumptions so that new meanings can be created (Nichols & Schwartz, 2006; White & Epston, 1990).

Second, externalization of problems is highly significant in Narrative theory, as it encourages individuals to objectify and personify the problems that they are experiencing as oppressive, without internalizing the problems as "themselves" (White, 2007; White & Epston, 1990). Externalizing seeks to separate the person's identity from the problem for which they need assistance (Morgan, 2000; White & Epston, 1990). Externalizing the problem(s) is one way to deconstruct the disempowering assumptions that may surround problems that have stemmed from negative internalized messages about the self (Nichols & Schwartz, 2006). Hence, Narrative theory allows for individuals to think of themselves as struggling *against* their problems instead of *having* a problem or *being* a problem (Freedman & Combs, 1996; Morgan, 2000; Nichols & Schwartz, 2006; White & Epston,

1990). The *problem* is the problem, rather than the individual and/or family (White & Epston, 1990).

Third, discovering and identifying unique outcomes is also a major concept in narrative theory. Unique outcomes are defined as any event(s) that seem to contradict or stand outside of the dominant problem story (Morgan, 2000; White & Epston, 1990). These events are also called "sparking events," as they shine and/or stand out in contrast to the dominant story (Morgan, 2000; Nichols & Schwartz, 2006; White & Epston, 1990). They can serve as doorways to alternative stories. Last, in reconstructing and reauthoring, new and alternative stories are formed. Reconstruction entails replacing the problem-saturated story with one that allows the individual to be successful despite the constraining factors in their lives (Epston & White, 1990). Overall, Narrative theory focuses on creating opportunities for individuals to tell their stories in ways that their problem-saturated stories are deconstructed. This deconstruction allows for new, powerful alternative stories to form (Hannen & Woods, 2012; Madigan, 2011; Morgan, 2000; Phipps & Vorsters, 2014; White, 2007; White & Epston, 1990).

The concepts of Narrative theory is significant to this study as it allowed the researcher to understand the dominant stories of the participants' experiences in family therapy in the RTF. From the experiences of the researcher, who has worked as a clinical therapist in a RTF, she commonly observed both internal and external parties involved in the care of the youth labeling them as "problematic." These labels appeared to become the dominant narratives of these youth's lives. Unfortunately, these SOC seemed to lack an understanding of how social inequalities impact the lives of disenfranchised populations. Far too often, treatment placed an emphasis on answering the question of

"*what is wrong with you?*" rather than "*what has happened to you?*" (Hardy, 2013). Even more devastating for these youth was that the same label existed within the familial context. These youths' families both implicitly and explicitly communicated to the youth: "*What is wrong with you? Why can't you just change and get over this? Don't you know that I have other things to do other than run up and down here to participate in therapy?*" Through this study, the researcher hoped to understand the experiences of Black youth in family therapy in the RTF, as well as in the larger context of the RTF residential culture.

Moreover, it is important to highlight here that a "parallel process" takes place in different societal systems. A "parallel process" is simply defined as "when two or more systems have a significant relationship with one another, develop similar affects, cognitions, and behaviors" (Bloom & Farrragher, 2011, p. 151). Parallel processes will be discussed more thoroughly in the Literature Review. Suffice it to say, the concept of "parallel process" highlights the similarities between the experiences of the adolescent within the context of their families and the families' experiences in the larger society. Even within a SOC that was designed to ultimately help them "succeed" and overcome the daily struggles of life, the question of "*what is wrong with these families?*" is emphasized in treatment, rather than "*what has happened to these families?*" (Bloom & Farragher, 2013; Hardy, 2013). An examination of the larger systemic problems that stem from the racial and economic oppressions of poor Black families has been ignored repeatedly. Future research needs to examine different parallel processes that take place in relegating underserved populations to disadvantaged positions.

Africana womanism prioritizes race, class and gender in conceptualizing and understanding the experiences of Black people. It strives for empowerment and assumes that race is of paramount importance of any deliberations on or about Black women (Ntiri, 2001). Africana womanism is also family-centered, thus, creating room for Black men to take part in bringing about social change. From this perspective, Black women do not perceive Black men as their enemy in the way that they contend white feminism does. Rather, the enemy is considered to be oppressive forces in the larger society which subjugate Black men, women and youth (Ladner, 1972, p. 277-278). Steady (1981) expands on Ladner (1972), stating:

> For the majority of Black women, poverty is a way of life. For the majority of Black women also, racism has been the most important obstacle in the acquisition of the basic needs for survival. Through the manipulation of racism the world economic institutions have produced a situation which negatively affects Black people, particularly Black women…. What we have then, is not a simple issue of sex and class differences but a situation which, because of the racial factor, is cast like in character on both a national and global scale (p. 18-19).

Similarly, the majority of the youth and families who become involved in the rehabilitation SOC are Black and come from impoverished backgrounds. The intergenerational patterns of poverty are vivid and profound. The intersectionality among race, class, gender and other variables has led to struggles with mental health, substance abuse and complex trauma (Hardy, 2007; Hardy & Qureshi, 2012).

Integrating Narrative and Africana womanism theories helps illuminate the unique experiences of Black adolescents in family therapy in the RTF. Likewise, the

multicultural perspective (MCP) allows the phenomenon to be better understood, through a socio-cultural lens. MCP permits an in-depth understanding of human relationships, as it promotes an understanding of the "other," the "self" and the "self in relation to other" (Hardy & Laszloffy, 2002). It is a philosophical stance that informs how individuals see the world, see others in the world, and most importantly, how they view themselves in the world. From this perspective, relationships are embedded in different contexts. MCP also highlights the importance of culture in the lives of individuals. For multicultural theorists, culture is a broad-based concept that is comprised of a host of interrelated dimensions that include race, gender, class, age and more (Hardy & Laszloffy, 1995; 2002).

Furthermore, Hardy and Laszloffy (2007) have identified four aggravating factors that play a critical role in initiating and/or maintaining adolescent violence*: (1) devaluation, (2) disruption/erosion of community, (3) dehumanization of loss, and (4) rage* (Hardy & Laszloffy, 2007). For Black adolescents, the cultural communities in which these underserved youth live are disrupted by forces of racism, sexism, classism, homophobia and anti-Semitism (Hardy & Laszloffy, 2007, p. 75). Overall, the Narrative, Africana womanism and MCP frameworks privilege the voice and narratives of the Black adolescents from their unique individual perspectives and experiences.

1.10 Contribution to the Field

Despite the exhaustive research that has been conducted in the field of mental health and adolescents, underserved populations, such as Black families have been underrepresented. In addition, research has tended to focus on youth and families that seek outpatient or in-home services, and far less so on inpatient services. The Couple and Family Therapy (CFT) profession plays a significant role in understanding relational

dynamics in an individual's life, as it relates to mental health treatment. Thus, it is important to understand inpatient experiences in the context of their families, as well as the larger society.

This study fills this gap in the literature by providing in-depth detailed descriptions of the experiences of Black adolescents in family therapy in a RTF from a cultural perspective. As Black youth are underserved and understudied, specifically in empirical research, the results of the study provided a deeper understanding of the needs of this vulnerable population. The findings of the study offered some insights to CFTs working with the Black RTF population, as it pertains to family therapy.

1.11 Conclusion

In sum, the present study expands and deepens the understanding of various socio-cultural contexts that influence Black adolescents' experiences in family therapy in a RTF. The transcendental phenomenological approach, effectuated through semi-structured in-person interviews, elicits the texture and nuance necessary for the participants' narratives to be meaningful and salient. Additionally, the application of three distinct theoretical frameworks makes this study's results multidimensional and unique to CFT.

CHAPTER 2: LITERATURE REVIEW

2.1 Overview of Chapter

This Literature Review is separated into two parts. First, it outlines the landscape of the mental health needs of the youth population in the US. This is accomplished primarily through the use of statistical data on the prevalence of certain mental health disorders, the demographics of the youth population and the prevalence of traumatic events among youth. Then, racial, class and gender disparities in diagnosis and treatment, across a range of psychiatric disorders, are discussed. The first part concludes by underscoring the importance of familial intervention in youth therapy, specifically, Multidimensional Family Therapy (MDFT), Brief Strategic Family Therapy (BSFT), Attachment-Based Family Therapy (ABFT) and Parent-Child Interaction Therapy (PCIT).

Second, the theoretical frameworks of the study are examined. Three (meta) frameworks are used: (1) Narrative theory, (2) Africana womanism theory, and (3) the multicultural perspective (MCP). Narrative theory contends that individuals give meaning to their socially-constructed world by arranging their experiences into narratives. Narrative theory focuses on *unique outcomes* to permit an individual to reauthor an otherwise counter-productive narrative and replace it with a new positive, agency-driven narrative (White & Epston, 1990).

Next, Africana womanism is an ideology that critically examines conventional feminist theory as overly gender-focused and ignoring the issue of race when it comes to addressing the patriarchal oppression of Black women (Hudson-Weems, 1993). Africana womanism proposes the addition of race- and family-centered foci to acknowledge the

uniqueness of the subjugation of Black women (people) in America. Finally, the MCP emphasizes the importance of the multi-dimensional roles of culture and context in shaping how individuals interpret their world (Hardy & Laszloffy, 2002). Aggravating factors such as devaluation, disruption/erosion of community, dehumanization of loss, and rage are discussed (Hardy & Laszloffy, 2005). This chapter concludes by applying the three theoretical frameworks to the context of Black youth's experiences in family therapy in a RTF.

2.2 Mental Health Needs of Youth

2.2.1 Statistics of General Youth Population

Mental health is a key component of a child's healthy development, impacting the ability to learn, grow and lead a productive life (Stagman & Cooper, 2010). Mental health problems are common among today's youth and unfortunately begin at a young age (Stagman & Cooper, 2010). The onset of major mental illness may occur as early as 7 to 11 years old and roughly half of all lifetime mental health disorders start by the mid-teens (Behan & Blodgett, 2003; Children's Defense Fund, 2010; Kessler, Amminger, Aguilar-Gaxiola, Alonso, Lee, & Ustun, 2007; Stagman & Cooper, 2010). Approximately 20% of the nation's youth are at risk for and have a diagnosable mental health disorder (Behan & Blodgett, 2003; U.S. Department of Health and Human Services, 1999). Within this population, 7-13% of these youth suffer from severe emotional disturbances that greatly affect their functioning with adaptive daily living skills (ADLs; Behan & Blodgett, 2003; Center for Mental Health Services, 1998).

One in five youth require treatment for emotional disturbances and mental health conditions, treatment which often does not occur because services are not accessed

(Allen, Pires, & Brown, 2010; National Institute of Mental Health, 2007; Stagman & Cooper, 2010). About half of those youth requiring treatment have mental health problems that are severe enough to impair how they function at home, in school, and/or in the community (Children's Defense Fund, 2010; Stagman & Cooper, 2010). This translates into an approximate total of 4.3 million youth who suffer from a mental health condition that results in significant impairments at home, at school, with peers and in the community (Characteristics of Residential Treatment, 2008). In 2007, more than 1 in 4 high school students reported feelings of depression that were severe enough to impair their daily activities (Children's Defense Fund, 2010). Ultimately, youth who are not able to function at home, school, and/or in the community are placed in higher levels of care (LOC), such as residential care and inpatient psychiatric hospitals due to danger of harming themselves or others. Most youth with severe behavioral disturbances get referred to RTFs because they are equipped to provide intense and acute level of care (Allen, Pires, & Brown, 2010; Stagman & Cooper, 2010).

Research findings indicate that the general population of youth in the US experiences many different types of mental health problems (Characteristics of Residential Treatment, 2008). The following statistics are provided by the Surgeon General's Report (1999):

- *Mood Disorders:* 6.2% of youth aged 9 to 17, with 5% who have major depression and 1% who have bipolar disorder;
- *Depression*: 10% to 15% of youth exhibit symptoms at any given time;
- *Psychoses*: 1% of youth have bipolar disorder or schizophrenia;
- *Disruptive disorders:* 10.3% of youth aged 9 to 17;

- *Substance abuse disorders:* over 20% of youth with mental health condition have co-occurring substance use conditions;
- *Anxiety disorders:* 13% of youth aged 9 to 17;
- *Eating disorders:* approximately 10% of youth; and
- *Chronic health conditions:* an estimated 10% to 15% of youth have chronic health conditions, frequently co-occurring with behavioral health conditions.

More recently, the American Academy of Children and Adolescent Psychiatry (AACRC; 2010) compiled the following statistics on child and adolescent mental illness:

- *Attention Deficit Hyperactivity Disorder (ADHD)*: estimated that 3-5% of children have ADHD, making approximately 2 million children in the United States;
- *Conduct Disorder*: affects 1-4% of 9-17 years old; more common in boys than girls;
- *Depression*: 1 in every 10 children and adolescents are affected by serious emotional disturbances;
- *Oppositional Defiant Disorder (ODD)*: affects 1-6% of school-age population; more common in boys prior to puberty however both genders are equal after puberty;
- *Eating Disorders*: approximately 5-15% in adolescents; more common in females as they are 10 times more likely to die because of the illness;
- *Suicide*: third leading cause of death between 15-24 years old; in 2007, 6.9% of high school students indicated that they had attempted suicide in the last 12 months and 14.5% had seriously considered attempting suicide;

- *Post-Traumatic Stress Disorder (PTSD)*: in a given year, 5.2 million Americans, which include children and adolescents who suffer from PTSD.

Merikangas, He, Brody, Fisher, Bourdon, and Koretz (2010) also conducted a study that reported results of parent and child mental health diagnostic interviews. Using the National Health and Nutrition Examination Surveys (NHANES), this particular study included 3,042 participants aged 8 to 15. Data was obtained from participants who completed the NHANES survey between 2001 and 2004. They selected specific mental health disorders to assess, which included generalized anxiety disorders (GAD), depressive disorders, panic disorders, eating disorders, ADHD and conduct disorders. The study summarized the following:

- One in eight children aged 8 to 15 (13.1%) met the criteria for any mental health disorder in the past year; 11.3% met the criteria for mental health disorder with severe impairment in the past year;
- Boys had a higher rate of any past year disorder than girls, primarily driven by the rate of ADHD;
- Girls had higher rates of mood disorders than boys;
- The most common disorders were ADHD, mood disorders, and conduct disorders among youth (Merikangas et al., 2010).

2.2.2 Demographics of Residential Youth Population

Many youth with severe mental health needs are often taken out of their homes and transitioned into residential care in an effort to provide therapeutic services to enhance their physical, emotional, intellectual, social/interpersonal and cognitive skills. In doing so, the goal is to return them to their communities to live safe, productive and

healthy lives (Allen, Pires & Brown, 2010; American Academy of Child and Adolescent Psychiatry, 2010). These youth often present with severe emotional and behavioral disturbances, along with family dysfunction. These disturbances and dysfunctions have led to the youth's removal from the home to utilize treatment in out-of-home placements, specifically RTFs, as they are unable to function in less restrictive settings (Zelechoski, Sharma, Beserra, Miguel, DeMarco, & Spinazzola, 2013). Youth placed in residential care have faced a broad range of family and mental health risks. These risks include: maltreatment, neglect, disturbed family interactions, extensive histories of trauma exposure and underprivileged environments, all of which contribute to poor social competency (Harr, Horn-Johnson, Williams, & DeJager, 2011; Zelechoski et al., 2013).

Given these risks, it is important to consider the unique characteristics of these youth so that mental health professionals are well-equipped to provide clinically appropriate services during the youth's residency in the RTF. Warner and Pottick (2003) examined demographic differences in the residential population, which included race, gender, and age. They analyzed data that was collected from a national survey conducted by the US Center for Mental Health Services. The survey included a sample of more than 8,000 youth admitted to 1,600 community mental health facilities. These facilities included clinics, hospitals, residential care programs (RCPs), and community centers.

The researchers concluded that approximately 75% of youth in RCPs are between the ages of 13 and 17, with a higher representation of males (61%) and white youth (65%), as compared to Black (21%) and Hispanic (12%) youth (Warner & Pottick, 2003). They also noted that, although generally consistent with the US population demographics, their findings were surprising given the high prevalence of Black and

Hispanic youth typically found in social service and juvenile justice programs (Warner & Pottick, 2003). Furthermore, youth in RCPs were amongst the most troubled. Approximately 72% experienced problems with family, 57% experienced problems in school, 22% suffered from skills deficits, 66% showed aggressive behaviors, 34% were involved in delinquent behaviors, 31% had substance abuse problems, 50% were victims of abuse or neglect and about one fifth experienced post-traumatic stress (Warner & Pottick, 2003).

Additionally, youth in the child welfare and juvenile justice system who are referred to RTFs with mental health issues do less well than those who are not involved in other systems of care (SOC; Stagman & Cooper, 2010). Statistically, fifty percent of youth in the child welfare system have mental health problems and 67-70% of youth in the juvenile justice system have a diagnosable mental health disorder (Stagman & Cooper, 2010). It is often difficult for youth who are involved in different SOC and require mental health treatment to be placed in permanent homes. They are also more likely to experience a placement change than youth who are involved in other SOC but do not present with any mental health problems. Least restrictive treatment options are utilized first and foremost until the child "fails-up" in the system, leading to more restrictive settings such as juvenile detention centers, inpatient psychiatric hospitalization, RTFs, or emergency rooms (Stagman & Copper, 2010).

2.2.3 Involvement in Other Systems of Care

Youth who have frequently experienced a variety of traumatic events resulting from chronic abuse and neglect often find themselves involved in the public child welfare system. These youth present with significant behavioral and treatment challenges to the

public school systems, the courts, as well as mental health and child welfare providers (Nisenbaum, 2013; Stagman & Cooper, 2010). More than 500,000 children live in foster care, with Black youth making up 45% of the children in public foster care (Child Welfare League of America, 2007). More than half of all youth waiting to be adopted are Black, as they have come to the attention of child welfare authorities mainly due to suspected abuse and/or neglect (DHHS, 1999a).

The needs of institutionalized Black youth are comprehensive and complex, often resulting in their simultaneous involvements in multiple agencies. Unfortunately, the services provided at interagency levels are without active coordination of care, which puts them at risk of receiving fragmented care that fails to address their overall needs (Winters & Pumareigo, 2007). The Child and Adolescent Service System Program (CASSP) system of care (SOC) model was specifically developed to coordinate and integrate care for these youth with complex mental health needs and to provide them and their families individualized, culturally competent services in the community whenever clinically appropriate (Winters & Pumareiga, 2007). These changes stemmed from the results of a study published by the Youth's Defense Fund, *Unclaimed Youth: The Failure of Public Responsibility to Youth in Need of Mental Health Services*, authored by Jane Knitzer in 1982. The study documented clear disconnects between policies and programs, which meant that youth with mental health needs and their families were not receiving the services that they needed (Cooper et al., 2008; Winters & Pumareiga, 2007). Furthermore, the results indicated that youth with serious mental health and emotional disorders were receiving care that was fragmented, uncoordinated, and largely

ineffective, often in institutions, such as RTFs, far from their homes (Cooper et al., 2008; Winters & Pumareiga, 2007).

The SOC model for youth's mental health required a change in service design and delivery, along with new financing strategies (Winters & Pumareiga, 2007). Since the development of the SOC model, mental health programs have striven to implement the CASSP values. The goals of CASSP were to: (1) reduce out-of-home placements, (2) reduce fragmentation in services, (3) promote earlier mental health intervention to reduce functional morbidity, and (4) maintain youth in their homes and communities (Winters & Pumareigo, 2007). Unfortunately, despite the implementation of the CASSP principles within mental health agencies, youth and families within the SOC continue to receive inadequate services that are not tailored to their individualized needs.

2.2.4 Traumatized Youth in RTFs

Unfortunately, more than half of the youth in the US have experienced a potentially traumatic event such as child abuse, sexual assault, domestic violence, community violence, bullying, serious accidents, fires, disasters, medical trauma or the traumatic death of a loved one (Cohen, Berliner, & Mannarino, 2010; Igelman, Ryan, Gilbert, Bashant, & North, 2008). It is estimated that 25% of youth in the US will be exposed to at least one "high magnitude" traumatic event by the age of 16, and 75% of youth will experience the loss of a family member or friend by the age of 10 (Coterllo, Erkanli, Fairbank, & Angold, 2002). In 2004, 872,088 youth were abused and neglected and of those with substantiated abuse, 62.4% were neglected, 17.5% were physically abused, and 9.7% were sexually abused (Child Welfare League of America, 2007). The

traumatic experiences of child abuse and neglect can lead to an assortment of emotional and behavioral challenges for youth (Igelman et al., 2008).

Adolescents commonly report direct or indirect exposure to trauma through a wide variety of experiences, such as witnessing a traumatic event, learning about a traumatic event, experiencing violent death of a sibling or peer, experiencing physical or sexual abuse and more (Harr et al., 2013). Youth exposed to traumatic events may experience both immediate and long-term difficulties, including depression, anxiety, anger, conduct problems, learning impairments, dissociation and developmental disturbances (Cohen, et. al, 2010; Collin-Vezina, Coleman, Milne, Sell, & Daigneault, 2011; Igelman et al., 2008; Putnam, 2003). Youth with histories of trauma, abuse and neglect are at high risk for experiencing social, emotional, behavioral, cognitive and physiological problems as they transition into adolescence and adulthood (Springer, Sheridan, Kuo, & Carnes, 2007; Igelman et al., 2008). Without early intervention, approximately one quarter of these exposed youth develop significant symptoms of Posttraumatic Stress Disorders (PTSD). They are also more likely to exhibit internalizing symptoms, such as suicidal ideations and self-injuries behaviors, as well as externalizing behaviors, such as running away, delinquency, and academic problems (Harr et al., 2013). Overall, they are at increased risk of psychiatric and medical problems which derail normal developmental processes.

The above disturbing statistics indicate the need for specialized treatment for youth who have experienced trauma in various domains (i.e. academics, family, community, etc.). Undoubtedly, youth who are admitted to RTFs require an array of clinical and therapeutic services, as they present with various behavioral, emotional,

psychological, familial, social and interpersonal challenges. Traumatized youth make up a substantial portion of youth in RTFs, as much as 50-70% (Bettmann, Lundahl, Wright, Jasperson, & McRoberts, 2011; Jaycox, Ebener, Damesek, & Becker, 2004; Warner & Pottick, 2003). Child maltreatment, domestic violence and other forms of early interpersonal trauma disrupt primary attachments and increase the risk of developing a constellation of difficulties referred to as "complex trauma" (Cohen, Mannarino, Kliethermes, & Murray, 2012). Complex trauma is characterized by significant problems with attachment security, affect regulation, biological regulation, dissociation, behavioral regulation, cognition, and self-concept (Cohen et al., 2012).

The literature supports a trend that shows positive correlation between trauma-related symptoms and restrictiveness of placement (Collin-Vezina et al, 2011). Youth in residential settings present with more negative symptoms than youth in other out-of-home placements. Youth placed in non-relative foster care also demonstrate higher severity of problems than youth in kinship care or who remain home during provision of services (Collin-Vezina et. al, 2011). The effects of trauma on the lives of adolescents have been highlighted; however little is known about the prevalence of trauma among youth entering RTFs or the unique ways in which it may impact their behaviors.

Harr et al. (2013) conducted a study with 457 participants who were admitted to a state-supported RTF in Texas. Their study reported approximately half of the youth experienced three or more traumas before entry to the residential care. The results indicated that the total number of traumas experienced was a greater predictor of risk behaviors among these youth than the specific traumas experienced. Also, internalizing behaviors such as self-harm and suicide attempts increased with the number of traumas

experienced by the youth. This study also revealed that the specific traumas that had the most significant negative effects on the youths' behavior often related to family events or interactions. These included the following traumas: loss of a parent, verbal abuse, sexual abuse, and family violence (Harr et al., 2013). Many of these high risk adolescents did not have the benefit of a strong nuclear family that provided ongoing support and protection. This supports the notion that there is a reciprocal linkage between parental and youth behaviors, and that parental involvement, or lack thereof, has a significant impact on youth (Harr et al., 2013).

The findings of Harr et al. (2013) were also consistent with the findings of The Odyssey Project, which was conducted by the Child Welfare League of America (CWLA) in 2005. This specific study focused on youth in residential care {specifically residential group care (RGC) and therapeutic foster care (TFC)} with a sample of 2,274 participants. Fifty-eight percent (n-1321) entered RGC programs, while 42% (n-953) entered TFC programs. Within the sample, 65% (n-1472) were males and 35% (n-802) were females. Roughly 40% of the children and youth in the RGC sample were Caucasian, compared to 62% of children and youth in TFC. Another 37% children and youth were African American, compared to 21% of the TFC children and youth. The average age of children and youth at entry into The Odyssey Project was 13.1 years, ranging from 3 to 20 years old. Children and youth entering TFC were significantly younger (11.9 years old) than those entering RGC (14 years old). A significantly larger percentage of youth (93%) who entered RGC had a psychiatric diagnosis in comparison to TFC. The three largest referral sources for the children and youth were: (1) county and local public child welfare agencies (39%; n-869); (2) state public child welfare agencies

(31%; n-705); and (3) juvenile justice system (18%; n-415). Less than 4% were referred by family, private practitioners, insurance companies, and other sources.

The findings of The Odyssey Project reported that most of the youth had multiple ongoing mental health, family-related and behavioral problems, which not only preceded placement, but continued during and after residential care. The CWLA (2005) study also found high levels of sexual abuse (38%), physical abuse (57%), domestic violence (34%), maternal drug (50%) and alcohol dependency (38%), maternal mental illness (30%) and psychiatric hospitalization (27%) among the participants. The data also suggest that youth in RCPs tend to be males who are older in age. They have prior living arrangements, along with greater frequencies of physical abuse, mental illness, delinquency and school problems (CWLA, 2005). Data collected from The Odyssey Project indicated that the goal for most youth entering residential care was to return home and that many youth achieved this goal. This finding highlights the importance of therapeutic work that needs to be conducted in family therapy during placement.

Conner et al. (2004) also recruited 397 youth who were treated in a residential treatment center. They found that there were high rates of internalizing and externalizing psychopathology, along with aggressive behaviors. With females, there were higher levels of internalizing and externalizing symptoms. They also found high rates of family violence, physical and sexual abuse with 33% of the sample reporting sexual abuse, 27% for males and 64% for females. This is 2-3 times the prevalence rates found in the general population (Connor et al., 2004; Putnam, 2003). Overall, youth in RTFs present to treatment with an array of different problems, one of which includes a history of and exposure to trauma, which affects their ability to self-regulate. These increased

behavioral and emotional problems ultimately become unmanageable if they go untreated. The lack of appropriate and early intervention leads to exhaustion of community-based services, moving towards treatment in residential care and/or involvement in other rehabilitation systems.

2.2.5 Traumatized Systems of Care

At times, residential treatment may be a necessary and desirable choice of treatment due to circumstances in which physical separation from the family and community setting is inevitable (mainly due to safety reasons). Despite being a necessity, the trauma and loss that is experienced from being removed from the family is one that may have a further detrimental impact on the youth. Other problems experienced by traumatized youth who are admitted to RTFs include: (1) stigmatizing labels associated with being "institutionalized;" (2) inability to transfer learned skills within a protective shelter environment to independent living and/or in the community; (3) the negative influence of adolescent peers whose problems have caused their own removal from the normal community life; (4) institutional structure and rules that prevent the development of individualized programs and oppose adolescents' normal needs for privacy and sexual expression; and (5) the risk of maltreatment, abuse and neglect (Ingram, Katz & Katz, 1991).

Issues of maltreatment, abuse and neglect that take place in residential facilities will be specifically highlighted as some critics, such as Sandra Bloom (1997), have argued that psychiatric facilities need to be "transformed" before services are effectively rendered to individuals and families. Bloom (1997) began her work as a psychiatrist treating adults in an inpatient psychiatric hospital in Philadelphia, Pennsylvania. She

recognized early on in her career that the adult clients that were being treated in her inpatient hospital-based program had experienced tremendous childhood adversity, leading to increased pathological symptoms. These symptoms were then exacerbated within the system that was providing treatment as the clients were being re-traumatized. The facilities that were "supposed" to create a sanctuary place for these clients to heal and recover from their traumas were ill-equipped to manage the demands of the psychological, social, and physical problems of the clients. These clients who came into the psychiatric facilities expecting help, understanding, and comfort, instead found rigid rules, humiliating procedures, conflicting and often disempowering methods, and inconsistent, confusing and judgmental explanatory systems. These clients were exposed to further "sanctuary-trauma" and "sanctuary-harm," terms that address the trauma the takes place within the SOC (Bloom & Farragher, 2013).

Specifically, sanctuary-trauma "occurs when an individual who suffered a severe stressor next encounters what was expected to be a supportive and protective environment but discovers only more traumas" (Bloom & Farragher, 2013, p. 142). Similarly, the concept of "sanctuary-harm" is applied to events in psychiatric settings that do not meet the formal criteria for trauma but involve insensitive, inappropriate, neglectful or abusive actions by staff or associated authority figures and invoke in clients a response of fear, helplessness, distress, humiliation or of lost trust in staff (Bloom & Farragher, 2013, p. 142). Instead of "creating sanctuary," the rehabilitative systems ultimately cause more damage in the treatment process. "Creating sanctuary" refers to the shared experiences of creating and maintaining physical, psychological, social, and moral safety within a social environment- any social environment- and thus reducing systemic

violence and counteracting the destructive parallel processes (Bloom & Farragher, 2013, p. 47). “Parallel processes” emerge when organizational problems began to mirror the problems in the clients and continue to unfold as organizations begin to buckle under the influence of toxic stress (Bloom & Farragher, 2011). More concretely, parallel processes are described as the following:

> When two or more systems- whether these consist of individuals, groups, or organizations- have significant relationships with one another, develop similar affects, cognitions and behaviors. They can be set in motion in many ways, and once initiated leave no one immune from their influence. Parallel processes move from one level of a system to another, changing form along the way. (Bloom & Farragher, 2011, p. 151)

Parallel processes can either be destructive or constructive in nature. They are not inherently negative or dysfunctional; it depends entirely on what is being “paralleled.” Parallel processes evolve unconsciously, outside of awareness, are at work in all human systems and can stand in as metaphors, if not actual representations, for each other (Bloom & Farragher, 2011, p. 150). Unfortunately, in the delivery of services in human services, parallel processes often occur destructively. Destructive parallel processes:

> Occur when another person, series of people, or an entire organization is drawn into re-creating destructive scenarios with people they are supposed to be helping. The results of the parallel process is that organizations and society, as a whole, frequently recapitulate for individuals the very experiences that have proven so toxic for them in the first place, while individual reenactments tend to shape the

> structure and function of those institutions. (Bloom & Farragher, 2011, p.150-151).

The outcome of these parallel processes is the development and maintenance of a traumatized system that is unable to provide effective treatment. The complex interactions between the traumatized clients, stressed staff, and pressured organizations create a social and economic environment that is frequently hostile to the aims of recovery (Bloom & Farragher, 2011, 2013). The bottom line is that there is no clear dividing line between "us" and "them"- between the people who need help and those that offer that help. Frequently, the helpers themselves are "wounded warriors" subjected to their own personal life experiences (Bloom & Farragher, 2011).

In sum, service providers have experiences in their background that may be quite similar to the life histories of their clients, hence hindering recovery. Bloom's (1997) work on sanctuary-trauma and destructive parallel processes within rehabilitation organizations clearly shed light on many systemic problems that exist in the service delivery in human services. Overall, her work with traumatized individuals and families led to the development of the "Sanctuary Model," which has been adapted nationally by human service organizations, including the RTF where data was collected for this study. As defined by Bloom & Farragher (2013):

> The Sanctuary Model addresses the theoretical and practical complexity necessary for organizational change. It is not a trauma-specific intervention as it functions underneath all the other things that go in a treatment program, all the approaches, kinds of therapy, techniques and practices. It is designed to change the operating system of the organization, that is, the organizational culture. It integrates long-

> establishing but often forgotten good organizational practice with the newer sciences of attachment, trauma, and interpersonal neuroscience. The Sanctuary Model is specifically designed to create the context within which groups of people in an organization are encouraged and supported to make what are sometimes radical shifts in the very foundations of the way they think, what they feel, how they communicate, and how they practice. (p. 29-30)

The primary goal of the Sanctuary Model is to facilitate the development of an organizational culture that can contain, manage, and help transform challenging life experiences that have molded and often deformed for the clients that are in the care of these organizations (Bloom & Farragher, 2013).

To achieve these goals, the Sanctuary Model is built upon the "four pillars" of sanctuary: (1) trauma theory, (2) the sanctuary commitments, (3) SELF, and (4) the sanctuary toolkit. Trauma theory provides the scientific underpinning for the Sanctuary Model. The sanctuary commitments provide the anchoring values and are tied directly to developmentally grounded, trauma-informed treatment goals as well as the overall health of the organizational culture (Bloom & Farragher, 2013). The SELF acronym stands for safety, emotional management, loss, and future. It is a simple and easy-to-use conceptual framework that provides a "compass" for everyone to navigate the challenges of complex interventions (Bloom & Farragher, 2013). SELF provides a non-linear, cognitive behavioral, therapeutic approach for facilitating movement that targets individual clients, families, staff problems and/or whole organizational dilemmas. The sanctuary toolkit offers practical, grounded tasks that support implementation (Bloom & Farragher, 2013). The Sanctuary Model sets the framework for re-working the SOC so that trauma-

informed care can be provided to the vulnerable populations involved in these rehabilitative systems.

2.3 Disparities in Mental Health for Minority Youth

Mental health is fundamental to overall health and productivity of all individuals. Mental health sets the foundation for thinking, learning, communicating, resiliency, and self-esteem that influences individuals in the contexts of their families, schools, communities and the workplace (U.S. Office of the Surgeon General, 2001). Research on mental health has focused on various topic areas that highlight the prevalence of mental health needs of diverse populations that reside in the US. Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities should be viewed readily through the lenses of racial and cultural diversity, which include race, class, gender, and age (U.S. Department of Health and Human Services (DHHS), 1999). Since the publication of *Unclaimed Youth* (Knitzer, 1982), over 25 years ago, there has been an explosion of knowledge about the biological and social determinants of youth's mental health issues, new understanding of how youth problems develop, and new ways of providing preventive and treatment services (Cooper et al., 2008). This section of the literature review will focus primarily on the differences in mental health needs of youth in reference to their race, class and gender, highlighting the importance of individualized treatment for young Black males and females currently residing in RTFs.

2.3.1 Race and Mental Health

Minorities have less access and availability to mental health services and are less likely to receive needed mental health services. The quality of mental health treatment

minorities receive is poor and they are underrepresented in mental health research (DHHS, 1999). There are various reasons that explain these disparities in mental health for minorities, one of which is the historical and present day struggles with racism and discrimination, which affects their mental health and contribute to their lower economic, social, and political status (DHHS, 1999). Previous studies have focused on mental health (MH) disparities in minority populations, perceived views on MH treatment, reasons for seeking MH treatment, quality of MH treatment, and outcomes of MH treatment. Despite targeting these areas for minority population and MH, there is scarce research on racial and ethnic minorities due to low rates of involvement in MH treatment. The findings of some of the studies are discussed below.

Cummings, Case, Ji, Chae, and Druss (2014) examined racial/ethnic differences in the perceived reasons for receiving MH treatment among adolescents, who recently experienced a major depressive episode (MDE). A total of 2,789 adolescent participants were pooled from four years of data (2005–2008) from the National Survey on Drug Use and Health (NSDUH), an annual, nationally representative, cross-sectional survey. NSDUH samples included non-institutionalized individuals, aged 12 years and older, in the US civilian population from all 50 states and the District of Columbia. Adolescents between the ages of 12 and 17 took part in the survey. The survey included a series of questions to assess whether the adolescent respondent experienced a MDE in the previous year according to DSM-IV criteria, as well as information about MH services use, the perceived reasons for MH treatment, socio-demographic characteristics, substance use and other externalizing behaviors, and health status (Cummings et al., 2014).

Race/ethnicity was assigned by the adolescent respondent and grouped into 5 mutually exclusive categories: (1) non-Hispanic white, (2) Hispanic, (3) Black, (4) Asian, and (5) other race/ethnicity. Those classified as "other race/ethnicity" reported more than one racial/ethnic background or a group with small sample sizes (i.e., Native American/Alaskan Native; Native Hawaiian/ Other Pacific Islander). Socio-demographic measures included age in years, an indicator for female gender, an indicator for adolescents who lived with both parents versus those who did not, a categorical measure of family income (<$20,000, $20,000–$50,000, $50,000–$75,000, >$75,000) and a categorical measure of health insurance status (any private insurance, public insurance, no insurance, insurance). Depression-related impairment was assessed by a dichotomous indicator of self-reported severe or very severe impairment (versus no, mild or moderate impairment) in at least one of the 4 domains: (1) chores at home, (2) school or work, (3) family relationships or (4) social life. General health status was measured with a dichotomous indicator for fair or poor self-reported health status (versus good, very good or excellent health).

The findings of the study reported that more than three-fourths of adolescents who experienced a MDE in the past year and received MH treatment were females. The mean age of the analytic sample was 15 years. When comparing socio-demographic characteristics across racial/ethnic groups, Black, Hispanic and Asian adolescents had lower family incomes compared to non-Hispanic white adolescents. A few differences were observed when examining substance use and other externalizing problems. When differences were present, racial/ethnic minorities generally reported lower levels of externalizing problems compared to non-Hispanic white participants. For example, Black

and Asian adolescents had lower symptom counts for alcohol and marijuana use disorders compared to non-Hispanic white adolescents. There were no racial/ethnic differences in the percentage that reported severe or very severe MDE-related impairment (Cummings et al., 2014).

Differences were also observed across racial/ethnic groups when examining the settings in which MH treatment was received. Black participants were more likely to receive MH treatment in a school setting than non-Hispanic white peers (70.4% versus 54.1%), but were less likely to receive MH treatment in an outpatient setting (68.6% versus 81.8%). Hispanic adolescents (72.1%) were also less likely than non-Hispanic white peers (81.8%) to receive MH treatment in an outpatient setting. Results from this national survey indicated that among treated adolescents with depression, there were distinct racial/ethnic differences in perceived reasons for their MH treatment. Compared to non-Hispanic white participants, some racial/ethnic minority groups were less likely to endorse reasons for treatment involving internal emotional distress, such as feeling depressed, afraid, or tense. By contrast, racial/ethnic minorities were generally more likely to report reasons for treatment involving externalizing or interpersonal problems, such as getting into physical fights or having problems at school. These differences in perceived reasons for treatment existed despite similar reports of specific symptoms of depression among racial/ethnic groups (Commings et al., 2014).

2.3.2 Gender and Mental Health

Gender differences in child and adolescent mental disorders fall into two main groups, *early on-set* disorders and *adolescent on-set emotional* disorders. Early on-set disorders include conduct disorder, autism, developmental language disorders, attention

deficit hyperactivity disorder (ADHD) and dyslexia, which all show a marked male preponderance. To the contrary, adolescent on-set emotional disorders, such as depression/mood disorders, anxiety disorders and eating disorders, show a marked female preponderance (Zahn-Waxler, Shirtcliff, & Marceau, 2008). It is noted that the origin of male and female preponderant problems are likely rooted partly in biological, physical, cognitive, social and emotional differences found in males versus females (Zahn-Waxler et al., 2008).

Research on gender differences and psychopathology in youth emphasizes the prevalence rates for different disorders at different ages for males and females (Zahn-Waxler et al., 2008). More recently, research has begun to examine the differences and similarities in the development, antecedents, correlations and consequences of different forms of psychopathology in both males and females (Zahn-Waxler et al., 2008). Additionally, more attention is being paid to problems previously ignored in one gender because they occurred less often, such as, antisocial behaviors in females and depression in males (Bell, Foster, & Mash, 2005; Pollack, 1998; Putallaz & Mierman, 2004). Empirical efforts have also focused primarily on either biological factors *or* childhood adversities that distinguish between male and female problems, with less research on how these factors interact with each other to influence development outcomes in youth (Zahn-Waxler et al., 2008).

The research that has been conducted on gender differences in psychiatric disorders and symptoms has clearly defined variations in males and females. There is a distinctive need for gender-specific mental health treatment as males and females present with different emotional, psychological, social and development needs. Several processes

have been noted that can produce these gender differences in psychiatric disorders and symptoms in childhood and adolescence. These include: (1) experiencing different environment risk factors, (2) experiencing different levels of the same environment risk factors, (3) having different biological processes or mechanisms of gene expression (such that these influences may be differentially amplified or diminished for one sex or the other), (4) requiring different thresholds of biological or genetic risk for serious problems to develop, and (5) differentially experiencing interactions of environmental and biological influence (Zahn-Waxler et al., 2008, p. 277).

These differences may be noted as *risk-by-gender* factors in which specific interactions emerge, suggesting that gender plays a role in the different mental health outcomes for males and females. One important gender difference to note in mental health outcomes is the high prevalence rates of males being diagnosed with conduct problems and females with depressive symptoms. Females show more fearfulness and anxiety than males and higher levels of effortless control than males, indicating that they are more compliant and better able to inhibit their actions (Carter, Briggs-Gowan, Jones, & Little, 2003; Else-Quest, Hyde, Goldsmith, & Hulle, 2006). Feelings of guilt, shame and sadness are also more common in females than males in childhood, along with the ability for females to hide disappointment (Brody, 1999; Zahn-Waxler et al., 2008).

Moreover, females are more likely to "read" other people for signs of approval and disapproval, reflecting a greater dependence on others for how they are viewed (Zahn-Waxler et al., 2008). Females often use indirect or relational aggression often that creates psychological damage in relationships rather than physical harm (Zahn-Waxler, Crick, Shirtcliff, & Woods, 2006). These differences in the social-emotional paradigm

continue to be highlighted through the life course for males and females from childhood to adolescence. These differences ultimately impact how males and females feel about themselves, hence males reporting a higher self-esteem than females (Zahn-Waxler et al., 2006; 2008). Particularly in adolescence, males are able to describe more positive aspects of themselves such as self-confidence and success expectations (Zahn-Waxler et al., 2008).

There is limited research on females that describe the needs and characteristics of females residing in RTFs. It can only be assumed that females who are placed in residential treatment programs may have higher levels of psychological disturbance than males in the same program (Connor et al., 2004). To test this assumption, Connor et al. (2004) conducted a study in Massachusetts, through the University of Massachusetts Medical School to: (1) describe characteristics of aggressive behaviors; (2) examine possible gender differences in psychopathology and behavioral problems; and (3) describe medical problems encountered with the child and adolescent population. The main purpose of the study was to address the above issues by describing a carefully and systemically evaluated sample of youth who were consecutively treated in a large, single-site RTF (Connor et al., 2004, p. 499).

The sample consisted of 397 consecutive admissions to a single RTF between 1994 and 2001. The demographics of the sample included: 80% were males (n-317), 64% were Caucasian, 17% were African American, 15% Hispanics, 1% were Asian American and 3% identified as mixed ethnicity. The researchers measured the following variables: (1) psychopathology, (2) hyperactive/impulsive behavior, (3) self-reported alcohol or substance abuse, (4) aggression, (5) family history, (6) placement history and (7) physical

and sexual abuse (Connor et al., 2004). The research study specifically highlighted the importance of defining “aggressive” behaviors as most youth and adolescents entering RTFs present with dangerously violent and aggressive behaviors in the home and the community.

The Modified Overt Aggressive Scale (MOAS) was utilized in the study to assess for 4 categories of aggression with the participants, which included: (1) verbal aggression, (2) self-aggression (self-injurious behaviors), (3) objective aggression (impulsive property destruction), and (4) other aggression (physical assault) (Connor et al., 2004).. The scale also examined frequency and severity of the aggressive behaviors. The results of the study are concluded below, specific to the variables that were examined.

- *Psychopathology & Behavioral Problem*: The primary psychiatric diagnoses were disruptive behavioral disorders (49%), affective and anxiety disorders (31%), psychotic disorders (12%) and others (8%). Almost all youth (92%) received more than one psychiatric diagnosis, with 39% of the youth receiving two diagnoses, 32% receiving three diagnoses, 20% receiving four diagnoses and 1% received five diagnoses. Females were more likely to have a primary diagnosis of affective and anxiety disorders, while males were more likely to have a primary diagnosis of disruptive behavior disorders. There were significant gender differences noted on conduct, anxiety and depression subscales, with females scoring higher than males on all 3 subscales. Lastly, females also scored significantly higher than males on both the internalizing and externalizing scales, leading to higher overall levels of psychopathology than males;

- *Impulsive Behavior and Substance Use*: Many youth in the sample reported using alcohol (25%) and drugs (28%), with females reporting significantly higher usage than males with regard to both alcohol and drugs;
- *Aggression*: Most youth (58%) in the sample were classified as aggressive. There was a significant gender difference on the MOAS, with females having higher scores in 3 categories (verbal, self-aggression, and other) of aggressive behaviors. Females also had significantly higher scores on the total of MOAS, indicating that overall females are more aggressive than males.
- *Family Histories & Characteristics*: In reference to living arrangements before admission, 57% of the youth were living with a biological parent, 43% with others, and 23% were in the custody of state protective services. For 65% of the sample, a parent or primary caregiver abused alcohol, with a significant gender difference in parental alcohol abuse. Parental alcohol was more common in the families of females by 76% and males by 62%;
- *Placement History*: For 7% of the sample, the current admission to the RTF was their first out-of-home placement. Nine percent of youth had one prior out-of-home placement, 39% had 2-4 placements, 26% had 6-10 placements and 19% had more than 10 out-of-home placements. Hence, 84% of the study youth had 2 or more out-of-home placements prior to the current RTF placement. Also, there was significant gender differences in the number of out-of-home placements, with females (65%) being more likely to have more than 5 prior placements than males (40%). Last, only 27% of the sample was teenagers at the time of their first out-

of-home placement, which indicates that youth are being removed from their homes at a younger age to be placed in residential care;

- *Physical and Sexual Abuse*: Almost half (47%) of the sample had been physically abused. Females (60%) were more likely to experience physical abuse than males (43%). Many youth had been sexually abused, with females (64%) being more likely to be sexually abused than males (27%). Females (46%) were significantly more likely to experience both physical and sexual abuse than males (18%). Moreover, when physical and sexual abuse was considered together, 59% of the females and 43% of the males were abused by a parent or caregiver. For 19% of females and 7% of males, the perpetrator of abuse was someone other than a parent or caregiver (Connor et al., 2004).

Overall, the findings of the Connor et al., (2004) study indicate the need for specialized mental health services for the residential population and highlights the need for gender-specific treatment. The results concluded that impulsivity and emotional dysregulation is a serious and significant problem for youth of both genders in residential treatment. The study summarized significant gender differences that emerged for several of the measures of psychopathology and behavioral problems, with females being more likely to be diagnosed with affective and anxiety disorders consistent with internalizing behaviors. Anxiety problems peaked at adolescence, particularly in females and were more common in females than in males even in early age (Zahn-Waxler et al., 2008). Males in this study were more likely to be diagnosed with disruptive behavior disorders, such as attention deficit hyperactivity disorder (ADHD), conduct disorder and oppositional defiant disorder (ODD), all of which are externalizing behaviors. Females

also consistently exhibited higher levels of psychopathology, with more significant family psychopathology and higher rates of multiple out-of-home placements than males. Females were more likely to abuse alcohol and drugs, per self-reports. Females exhibited higher levels of verbal aggression, physical assault and self-injurious behaviors.

The findings of the Connor et al. (2004) study are consistent with the results of another study conducted by Hussey and Guo (2002). This study concluded that females, who are placed in residential treatment, are more likely to present with particularly high levels of pathology and behavioral problems. Hussey and Guo's (2002) study aimed to identify profile characteristics for a sample of 142 consecutively admitted children to residential treatment. The subjects were predominately preadolescent children ranging from 5 to 13 years old, referred state-wide from Ohio's child welfare, mental health, education and juvenile justice systems. Over 95% of the children were covered by Medicaid, with most children having grown up in poverty. Their findings were indicative of younger age, females and lower IQs to be associated with increased levels of psychopathology. The LOC in the residential facility was strongly linked to high levels of behavioral symptomatology.

Wiesner and Kim (2006) have also provided substantial evidence that adolescents with high levels of delinquency are high risk for depressive symptoms. They examined co-occurring problems of delinquent behavior and depressive symptoms in a longitudinal sample of 985 middle-adolescent males and females. The results solidified previous findings that there is an overlap between delinquent behavior and depressive symptoms with females reporting higher rates of co-occurrence than males (49.5% to 25.3%). Particularly, approximately one half of the females in the high level delinquent group

estimated to be in the high-level depressive group, leading to both problem behaviors being mutually predictive of each other for females. In simpler terms, females who are experiencing delinquent behaviors will additionally experience depressive symptoms at the same level and vice versus.

Conduct disorder is one of the two most common diagnoses found in youth entering residential treatment (Shabat, Lyons, & Martinovich, 2008). A conduct disorder diagnosis is used to identify youth with "a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms are violated causing clinically significant impairment in social, academic, or occupational functioning" (American Psychiatric Association, 2000, p. 68). Behaviors that are included in this diagnosis include aggression toward people and animals, destruction to property, deceitfulness or theft and serious violations of rules (Cameron & Guterman, 2007).

Along with conduct disorder being an indicator of delinquent behaviors, it has also predicted an increase in depressive symptoms among adolescent males and females (Hops, Lewinsohn, Andrews, Roberts, 1990). Depressive symptoms are inclusive of isolative behaviors, diminished interest in social activities, changes in sleep and appetite, depressed mood (most of the day), and feelings of worthlessness (American Psychiatric Association, 2000). The Ontario Child Health Study, a cross-sectional community survey of Ontario children ages 4 to 16 years old, examined areas of prevalence, risk indicators and service utilization in mental health for a six month period. The study reported that 31.3% of the females and 18.6% of the males diagnosed with conduct disorders at ages 4-11 had a comorbid mood disorder, and this co-occurrence increased to 48.1% for females

in adolescence and decreased to 15.3% for adolescent males (Offord, Adler, & Boyle, 1986).

The findings of The Ontario Child Health Study are consistent with the *gender paradoxic theory.* This theory states that females, compared to males, have a lower prevalence rate of conduct disorder and most if its comorbid conditions, with the exception of depressive symptoms *(*Loeber and Keenan, 1994). "Comorbidity" refers to the existence of two or more illnesses in the same individual at the same time (Spady, Schopflocher, Svenson, & Thompson, 2005). In reference to adolescents and mental health, comorbid conditions would include substance abuse disorders, mood disorders, anxiety disorders and more. The paradoxical effect emphasizes that the severity of disruptive behaviors is typically higher for females compared with males when the probability of the comorbid conditions is taken into account. Therefore, it can be expected that once females qualify for a disruptive behavior disorder, the risk for developing comorbid conditions is higher in females than males (Loeber & Keenan, 1994).

Not only does comorbidity in adolescents exist in mental health conditions and/or disorders, there is a relationship between psychopathology and medical status among youth in residential care. Nelson et al. (2011, 2012) research studies noted the importance of assessing, evaluating and treating both mental health and physical health of individuals, as growing evidence suggests that youth are at increased risk for mental health and physical health problems. The Nelson et al. (2011) study consisted of 1744 youth (61.2% males), who were between the ages of 8 and 18, entering a large residential treatment program between 2000 and 2010. The sample was ethnically diverse: 49.7 %

were white, 23% were Black, 10.4% were Hispanics, 7.2% were Native American, 0.9% were Asian/Pacific Islander and 8.4% were multi-racial. Approximately one-third (33.7%) of the youth had a physical health diagnosis at the time of intake. Asthma was the most prevalent condition diagnosed in 15.3% of the sample. Girls were significantly more likely to have a diagnosis than were boys (37.1% vs. 31.5%). Age was not associated with diagnostic status. Rates of physical health conditions differed significantly by ethnicity with Black (36.4%) and white (35.4%) youth with the highest rates, and Hispanics youth (23.2%) with the lowest (Nelson, Smith, Hurley, Epstein, Thompson, & Tonniges, 2011).

Furthermore, Nelson et al. (2012) specifically examined the association between psychopathology and physical health problems among youth in residential treatment. The sample included 606 participants aged 8 to 18 years, who entered the Boys Town Nebraska Treatment Family Home Program between 2003 and 2010. Youth sample was 60.2% males and showed some diversity (52.6% European American, 19.2% African American, 11.8% Hispanic American, 6.6% Native American, 0.8% Asian/Pacific Islander, and 8.9% multi-racial). The results of the study indicated higher levels of youth psychopathology, particularly internalizing problems, and were associated with greater risk for physical health problems and more prescription medication. Psychopathology comorbidity was also associated with physical health problems (Nelson et al., 2012).

Spady et al. (2005) also found that youth with a variety of behavioral and emotional disorders, such as psychosis, depression and hyperactivity, had higher levels of medical comorbidity in comparison to youth with no mental health diagnosis. Their study consisted of 406,640 children (50.6% males) between the ages of 6 and 17 years old

residing in Alberta, Canada during the fiscal year of April 1, 1995 to March 31, 1996. The results concluded that 32,314 (60.3% males) children were diagnosed with psychiatric disorders. Psychiatric comorbidity was present in 13.6% of the children. Comorbidity was present in all 3 psychiatric groups (psychotic disorders, emotional disorders and behavioral disorders) and peaked in post pubertal children. More girls than boys had significant medical comorbidity such as bronchitis and sinusitis. Children with psychiatric disorders had significantly greater medical services usage than did children without psychiatric disorders. Girls also had greater medical health care usage than boys (Spady et al., 2005). Similarly, other studies have reported that the presence of a mental health diagnosis and the severity of psychopathological symptoms (Angel & Angel, 1996; Lavigne, Binnnes, Arend, Rosenbaum, Kaufer, Hayford, & Gibbons, 1998) are both associated with higher levels of medical services utilization among youth (Nelson et al., 2012; Spady et al., 2005).

As adolescence is a developmental stage frequently characterized by an increase in risky behaviors (i.e. substance use, risky sexual behaviors) and a decrease in healthy, safe behaviors (i.e. physical activity, safe sexual behaviors), understanding the linkage between psychopathology and physical health is highly relevant (Nelson et al., 2012). Brooks, Harris, Thrall, and Woods (2002) found that adolescent mental health symptoms were associated with increased health-risk behaviors such as tobacco use, involvement in physical fights and sexual activity without use of birth control. Moreover, other research has concluded that youth with mental health disorders, such as attention deficit hyperactivity disorder (ADHD; Cuffe, Moore, & McKeown, 2009), depression, (Bennett, 1994), anxiety (Bardone, 1998) and conduct disorder (Pajer, Kazmi, Gardner, & Wang,

2007), all tend to have worse physical health outcomes than those without a diagnosed mental health condition (Nelson et al., 2012).

The Cuffe et al. (2009) research study concluded that youth with ADHD were two times more likely to have asthma and three times more likely to experience headaches than youth without ADHD. Another study concluded that adolescent females with conduct disorder have significantly worse physical health and fewer healthy behaviors than young females without a mental health diagnosis (Pajer et al., 2007). Bardone and colleagues (1998) conducted a longitudinal study with adolescent females with mental health diagnosis. The results concluded that a diagnosis of conduct disorder, depression and anxiety at age 15, were all independently associated with at least twice as many medical problems at age 21. Another longitudinal study also examined youth over period of 20 years, which suggested that psychiatric comorbidity in youth may be associated with worse physical health in adulthood (Chen, Cohen, Crawford, Kasen, Guan & Gorden, 2009). Youth who endorsed comorbid psychiatric symptoms at baseline had significantly worse physical health 20 years later than those who endorsed symptoms from only one disorder and those with no diagnosable symptoms (Chen et al., 2009).

Overall, psychopathology comorbidity is common in the adolescent youth population, specifically those youth who have diagnosable mental health disorders and enter residential treatment. The above research studies have contributed to the literature by setting a framework for future researchers to examine the residential population. For adolescents, there have been gender variations noted in mental health diagnoses, risk factors, family histories, psychopathology and comorbidity. These issues need to be

explored qualitatively to gain an in-depth understanding of these conditions in relationship to one's race, gender, class and age.

2.3.3 Class and Mental Health

Children represent 24% of the U.S. population and they comprise 34% of all people in poverty (Addy, Engelhardt, & Skinner, 2013). The percentage of children living in low-income families (both poor and near poor) has been on the rise, increasing from 40% in 2006 to 45% in 2011 (Addy et al., 20130). Among all children under the age of 18 years old, 45% (32.4 million) live in low-income families and approximately one in every five, 22% (16.1 million), live in poor families. There is a range of factors associated with children's experiences of economic insecurity, which include: race/ethnicity, parental education and employment status (Addy et al., 2013). The percentage of children in low-income families also varies by age. The following data are available on these variations for low income families: (1) forty-nine percent of children under 3 years of age (50.6 million); (2) forty-eight percent of children 3 through 5 years old (5.9 million); (3) forty-five percent of children 6 through 11 years old (10.9 million); and (4) forty-one of children 12 through 17 years old (10 million) (Addy et al., 2013).

Children's mental health is affected by their families' poverty histories. Poor children are at a greater risk for mental health problems than non-poor children, whether a consideration is placed on internalizing or externalizing disorders. Many minority youth suffer from inequalities in socioeconomic status, education, and access to culturally and linguistically appropriate health and human services (Pumareiga et al., 2005). These inequalities are reflected in significantly lower mean household incomes and levels of education, higher mortality rates, higher school drop-out rates, high teenage pregnancy

rates, unemployment and higher rates of physical and mental health disparities (Stagman & Cooper, 2010; U.S. Office of the Surgeon General, 1999, 2001). In the US, 21% of low-income youth, aged 6 to 17, have mental health problems, and 57% of youth with mental health problems come from households living at or below the federal poverty level **(**Stagman & Cooper, 2010).

Additionally, children in minority groups have high rates of poverty, with Hispanic children making up the largest group of poor children under 18 years old. The 2011 data on race/ethnicity by family income found that 65% of Black children (6.5 million) and 65% of Hispanic children (11 million) live in lower income families (Addy et al., 2013). Previously, in 1999, about 22% of Black families had incomes below the poverty lines ($17,029 for a family of 4) compared to only 10% of all U.S. families (U.S. Census Bureau, 2001c). Blacks are more likely than whites to live in severe poverty, with incomes at or below 50% of the poverty threshold. The rates of severe poverty for Blacks are more than 3 times the rates of whites. Additionally, Black families tend to live in and out of poverty; however, their periods of poverty tend to last longer, making them more likely than whites to suffer from long-term poverty and its consequences (O'Hare, 1996). The length of time that families remain in poverty increases the risk of mental health problems in children (McLoed & Shanahan, 1996).

Lower-income Black youth and families continue to live in segregated neighborhoods and live among other Blacks who are poor. Poor neighborhoods have fewer resources than economically privileged communities, a disadvantage reflected by high unemployment rates, homelessness, crime and substance abuse (Wilson, 1987). Youth in these environments often experience the following hardships: (1) increased

exposure to violence; (2) more likely to suffer from the loss of loved ones; (3) to be victimized; (4) attend substandard schools; (5) suffer from abuse and neglect; (6) encounter minimal opportunities for safe, organized recreation and other constructive outlets (National Research Council, 1993). Personal vulnerabilities are also exacerbated by problems at the community level, beyond individual control (U.S. Office of the Surgeon General, 1999, 2001). These disparities in socio-economic status for lower-income Black families might be associated with family structure, racial discrimination and economic oppression. Given these societal divisions, it is not surprising that traumatized youth make up a substantial portion of youth in residential treatment programs with reported rates as high as 71 percent (Zelechoski et al., 2013).

2.4 Black Families in Family Therapy

In the past few decades, scholars have shown interest in learning about culturally diverse ethnic groups residing in the US. Research studies are paying more attention to areas of cultural diversity with the intent to understand the mental health needs of underserved populations. Historically, evidence-based practices (EBPs) have primarily focused on studying upper-middle class Caucasian families. Researchers have started to test specific EBPs with other minority families, who are seeking mental health treatment. To provide effective treatment to these underserved populations, several models of family therapy have been tested with minority families, specifically Black families. Some examples of EBPs that have conducted research on minority families include: multi-dimensional family therapy (MDFT); brief strategic family therapy (BSFT); attachment-based family therapy (ABFT); and parent-child interaction therapy (PCIT).

Each of these family therapy model targets problem areas in the youth population, while examining the influence of families on those challenges. Their areas of interest include: behavioral problems (i.e. delinquency, truancy, oppositional and defiant behaviors); emotional problems (i.e. suicidal ideations, depression, anxiety); high-risk sexual behaviors; substance abuse; academic problems; and family functioning (attachment, structure and boundaries). This section of the Literature Review will discuss the primary tenets of these 4family therapy models, along with highlighting the research findings of these EBPs with Black families, which has been scarce. Other findings of qualitative research studies with Black/African American families will also be highlighted.

2.4.1 Multidimensional Family Therapy

Multidimensional Family Therapy (MDFT) was developed by Howard Liddle (1985) at the University of Miami, Miller School of Medicine, Florida. Liddle (1985) showed interest in understanding the impact of the family and larger social systems that may be contributing to and sustaining problematic behaviors in youth. MDFT is a family-based, comprehensive treatment system for adolescent drug abuse and related behavioral and emotional problems. It is widely recognized as an effective science-based treatment for teen substance use disorders and delinquency. MDFT is theory driven as it combines aspects of family systems theory, development psychology and the risk and protective model of adolescent substance abuse (Liddle, Dakof, Henderson, & Rowe, 2011). MDFT therapists work simultaneously in 4 interdependent treatment domains: (1) adolescent, (2) parent, (3) family, and (4) extra-familial (external social systems). MDFT clinical interventions work from “parts” (subsystems) to larger “wholes” (systems) and then from

these larger units (family/family relationship) back down to smaller units (individuals) (Liddle, 2013, p. 92).

MDFT consists of the following 3 stages: (1) building a foundation for change; (2) facilitating individual and family changes; and (3) solidifying changes and launching (Liddle et. al., 2011).While navigating through these 3 stages, MDFT therapists are guided by 10 basic principles. These principles include: (1) adolescent drug abuse is a multidimensional phenomenon; (2) family functioning is instrumental in creating new, developmentally adaptive lifestyle alternatives for adolescents; (3) problem situations provide information and opportunity; (4) change is multifaceted, multi-determined, and stage oriented; (5) motivation is malleable but it is not assumed; (6) multiple alliances are required as they create a foundation for change; (7) individualized interventions foster development competencies; (8) treatment occurs in stages; continuity is stressed; (9) therapist responsibility is emphasized and (10) therapist attitude is fundamental to success (Liddle, 2013, pp. 88-89). Overall, MDFT focuses on targeting specific areas of change, which include the youth, the parent, family interactions and the community social subsystems that influence the individual's problematic behaviors. The goal here is to decrease the risk factors by enhancing protective factors for the youth and family who is receiving treatment (Liddle, 2013; Liddle et al., 2011).

Numerous studies have been conducted over the past 3 decades with MDFT examining the effectiveness and efficacy of the model in relation to problematic behaviors in adolescents. The research projects have been conducted at sites across the US with diverse samples of adolescents (African American, Hispanic and Caucasian youth between the ages of 11 and 18) of varying socioeconomic backgrounds. MDFT has

also expanded internationally with over 440 clinically referred adolescents in Germany, France, Switzerland, Belgium and the Netherlands. MDFT has demonstrated efficacy in comparison to several other active treatments, including a psycho-educational multifamily group intervention, peer group treatment, individual cognitive behavioral therapy (CBT) and even residential treatment (Liddle, 2013, p.93). Overall, MDFT has shown success in the following areas:

- *Substance Abuse*: MDFT-treated youth showed reduction in drug use between 41-66% from baseline to treatment completion. These outcomes remained consistent at 1 year follow-up;
- *Psychiatric Symptoms*: MDFT-treated youth showed greater reductions in psychiatric symptoms than other comparison treatments, such as individual CBT. MDFT participants showed 30–85% within-treatment reductions in behavior problems, such as delinquent acts, depression, anxiety and aggression (both internalizing and externalizing symptoms); MDFT demonstrated superior and stable outcomes after one year with more severely impaired adolescents;
- *School Functioning*: MDFT-treated youth have shown to return to school and receive passing grades at higher rates. They also showed significantly greater increases in conduct grades than a comparison peer group treatment;
- *Delinquent Behaviors*: MDFT-treated youths have shown decreased delinquent behaviors and associations with delinquent peers, with outcomes being maintained at 1 year follow-up. Department of Juvenile Justice records indicate that compared to teens in usual services, MDFT participants were less likely to be arrested or placed on probation, and had fewer findings of wrongdoing during the

study period. MDFT-treated youth have also required fewer out-of-home placements;

- *Family Functioning*: MDFT-treated youth reported improvements in relationships with their parents. On behavioral ratings, family functioning improves (e.g. reductions in family conflict, increases in family cohesion) to a greater extent in MDFT than family group therapy or peer group therapy (observational measures), and these gains are seen at one year follow-up. MDFT-treated youths also reported gains in individual, developmental functioning on self-esteem and social skill measures.

Specifically, in relevance to this study, it is important to discuss the role of MDFT in providing treatment to Black families. Becker and Liddle (2001) examined the MDFT treatment approach to working with unmarried African American mothers and their adolescents in family therapy. They hypothesized that addressing the intrapersonal functioning of African American single mothers is vital if they are to re-establish the healthy attachment bonds that are necessary for the maintenance of essential parental influence in the lives of their adolescents (Becker & Liddle, 2001). A thorough description of the demographic information regarding the participants was not provided in the article, as several case study examples were discussed. The authors highlighted that the population was African Africans, which came from lower-income single parent female-headed households.

The results of the study indicated that MDFT was successful in retaining the family (mother and youth) in participating in family therapy if therapists worked towards providing flexibility, supportive reciprocity in communication and consistency in purpose

(Becker & Liddle, 2001). The findings suggested that service providers need to understand the nature of societal burdens, such as racism and sexism. Services providers should be prepared to help these mothers reconcile the tensions implicit to their roles as women, as African Americans, as mothers and as members of communities within a society that offers them little to no support (Becker & Liddle, 2001). This implicates a clear necessity to understand the intersectionality of different contexts, such as race, gender, family structure and socio-economic status, for Black families seeking therapy.

Robbins, Liddle, Dakof, Turner and Alexander (2006) also examined the adolescent and parent therapeutic alliances, receiving MDFT, as predictors of dropout from therapy. The research study encompassed 30 adolescents and their families who received MDFT for the treatment of adolescent drug use. The participants were selected from the archives of prior research studies that were conducted with MDFT. The mean age of adolescent participants was 14.93 years, with 24 males and 6 female adolescents. Of the participants, 80% were African American (n-24), with the remaining adolescents being non-White, Hispanic (n-5) and White Hispanic (n-1). Adolescents were referred from juvenile justice (60%), school (30%), and self-referred (10%). The majority of the adolescents resided in single-parent female headed households (n-18), with only 4 adolescents living in two-parent headed household. Most families resided in urban areas (90%) and reported an annual household income that was below the poverty line with 11 families earning less than $10,000, 10 families earning $10,000-$25,000, and 9 families earning greater than $25,000. More than half of the households included other siblings.

The results of the study demonstrated significant pretreatment differences between dropout and completer groups. Adolescents who dropped out of treatment were,

on average, older and reported fewer internalizing and externalizing symptoms than those who completed treatment. The dropout rates were also judged by their parents to have fewer externalizing symptoms. No differences were observed with gender, drug involvement, drug use, age of onset of alcohol or marijuana use and parent reports of adolescent internalizing symptoms (Robbins et al., 2006). Therapeutic alliance in family therapy with adolescents and their parents was measured during session 1 and session 2. The results indicated that the session 1 to session 2 change in alliance was statistically significant for the dropout adolescents. On the contrary, the session 1 to session 2 changes in alliances were not significant for the completer adolescents. This suggests that a significant reduction in alliance occurred for the dropout families from session 1 to session 2, but this decline did not occur for the completer families.

In sum, the findings of this study highlight the importance and complexities of the therapeutic alliance in family therapy with adolescents who abuse drugs. The alliances of both parents and youth declined over the first two therapy sessions in families who dropped out of treatment, but not those who remained in treatment. There was no data provided on which families dropped out of the session in reference to racial differences. However, because 80% of the participants were African American, it can be assumed that a strong therapeutic alliance may influence engagement and retention with African American families who seek therapy. The first and second therapy sessions are crucial to the therapeutic process in retaining African American families, which already show ambivalence to the SOCs. The authors also did not provide clarification on which families dropped out of treatment relative to their referral source. Families who are referred through the juvenile justice system are usually mandated to complete treatment

and have very little flexibility in dropping out of services. Further research needs to expand on understanding if other variables (i.e. such as referral source) influence dropout and completing rates.

Robbins et al. (2006) did provide racial and gender data on the therapists. There were 3 female and 2 male therapists, with 3therapists identifying as African American and the other 2 as White, Non-Hispanic. Despite this disclosure of information, there was no discussion on how the therapists were assigned to these families. Additionally, there was no discussion of the demographic characteristics (i.e. race, gender, age, SES, etc.) of the therapists that may impact the therapeutic alliance, which might influence the dropout versus completion rates in MDFT treatment. Further research needs to be conducted in these areas to fully capture the experiences of African American families and the therapeutic process with specific EPB models.

2.4.2 Brief Strategic Family Therapy

Brief Strategic Family therapy (BSFT) evolved from more than 25 years of research and practice at the University of Miami. It was developed by Jose Szapocznik (1975) to serve the Hispanic population in Miami to provide culturally competent mental health services. In the 1970s, there was a tremendous increase in the number of Hispanic adolescents involved with drugs. To respond to this crisis in the local Hispanic community, the Spanish Family Guidance Center adapted Structural Family Therapy (SFT) as its core approach. Over time, to meet the cultural demands and needs of the Hispanic population, SFT was refined to incorporate both structural and strategic interventions that are both time-limited and family-orientated (Robbins & Szapocznik, 2000; Szapocznik & Williams, 2000; Szapocznik, Zarate, Duff, & Muir, 2013).

BSFT has evolved as an evidence-based, culturally sensitive family intervention, which reduces delinquency and drug use in adolescents, while simultaneously strengthening the family unit. It is a structured, problem-focused, directive, and practical approach that treats the following: conduct problems; associations with antisocial peers; early drug use; maladaptive family interactions (relations); and other recognized youth risk factors (Santisteban, Szapocnik, Perez-Vidal, Kurtines, Murray, & LaPerriere, 1996; Szapocznik & Williams, 2000; Szapocznik, et al., 2013). To meet the goals of treatment of restructuring interactions and changing systems, BSFT addresses family behavior, affect and cognitions. The therapeutic process uses techniques of joining, diagnosis and restructuring. The following 4 steps of interventions are utilized in BSFT:

(1) ***Organizing a therapist-family work team*****:** entails developing a therapeutic alliance with each family member and with the family as a whole. This requires therapists to accept and demonstrate respect for each individual family member and for the family as a whole;

(2) ***Diagnosing the nature of family strengths and problematic relationships*****:** emphasis is placed on those family relationships that are supportive or problematic and on inappropriate responses;

(3) ***Developing a treatment strategy*****:** aims at capitalizing on strengths and correcting problematic family relations in order to increase family competence. In doing so, the therapist's approach is planned, problem-focused, direction-oriented (so s/he can move from problematic to competent interactions) and practical;

(4) ***Implementing change strategies***: involves reinforcing family behaviors that sustain new levels of family competence. Therapists use change strategies to

include the following: (a) use of reframes to change the meaning of interactions; (b) shifts in the nature of alliances and interpersonal boundaries; (c) building conflict resolution skills; and (d) providing parents with guidance and coaching (Robbins & Szapocznik, 2000; Szapocznik, Schwartz, Muir & Brown, 2012; Szapocznik & Williams, 2000; Szapocznik et al., 2013).

Overall, BSFT is a short-term family therapy model that delivers services in 12-16 family sessions, with as few as 8 and as many as 24 sessions, depending on the severity of the patterns of problem behaviors. It was designed to: (1) prevent, reduce, and/or treatment adolescent behavior problems, such as drug use, conduct problems, delinquency, sexually risky behaviors, aggressive/violent behaviors and association with antisocial peers; (2) improve pro-social behaviors, such as school attendance and performance; and (3) improve family function to include effective parental leadership and management, positive parenting and parental involvement with the child and social systems (i.e. peers and school) (Santisteban et al., 1996, p. 35).

In examining the literature on BSFT, it is noted that majority of the studies began with researching the effectiveness and efficacy of the model with primarily Hispanic youth, residing in Miami. Over the course of several decades, BSFT has shown promising results when used across racial/ethnic groups in the US, specifically African American families. BSFT has been implemented in different community settings, such as family homes and schools, which has increased involvement of all parties. The flexibility of the therapist to conduct mobile therapy has increased retention in therapy and family participation. It has also shown to reduce adolescent drug use and related risk-taking

behaviors, along with reconfiguring family interactions to support healthy development of all members (Szapocnik et al., 2012).

Specifically, Santisteban, Coatsworth, Perez-Vidal, Mitrani, Jean-Gilles, and Szapocznik (1997) examined the impact of BSFT on two risk factors, behavior problems and poor family functioning. The core assumptions of the research project were that BSFT would: (1) reduce the level of behavior problems; (2) improve the level of family functioning; and (3) that changes in these important risk factors reduce the likelihood that adolescents will initiate substance use (Santisteban et al., 1997). Participants in the research were families of African American or Hispanic decent with an adolescent between the ages of 12-14 years old. The adolescents had to meet the following criteria, as determined by the researchers: (a) externalizing behavioral problems (conduct problems at home/school, peer-based behavior problems and violent behaviors), (b) internalizing behavioral problems (anxiety and/or depression; suicidal ideations but not attempts), (c) significant academic problems, except organic learning disabilities and lastly, (d) initiation of alcohol or drug use. The researchers utilized appropriate scales/subscales to measure these problematic behaviors in the adolescents and their family functioning. Information on the specifics of the scales that were utilized in the study can be sought by referring to the article referenced here.

The study comprised of 122 adolescents (103-Hispanics and 19- African Americans) with 81 males and 41 females with a mean age of 13.1 years. The majority of the families were composed of the adolescents, two parental figures (parent, stepparent, guardian) and at least one sibling. The pretest data showed that the sample had elevated intake scores on all behavioral problems and family functioning scales, which suggested

high risk for substance abuse. Comorbidity of behavioral problems was also prevalent with 46% of the sample exhibiting elevated scores on the anxiety-withdrawal scale and at least one other two "externalizing" scales. In reference to family functioning, 43% of the adolescents reported that their family's overall functioning was in the problem range, while 34% of the parents reported problems in family functioning. Lastly, 65% of the sample showed both problems in family functioning and elevated behavioral problem scores.

The results of the study were divided into the following analysis categories: (a) program effects on intermediate outcomes in behavior problems and family functioning, (b) program effects on intermediate outcomes by ethnicity, and (c) program effects on ultimate outcome in preventing initiation of substance use and treatment effects on substance abuse (Santisteban et al., 1997). The results concluded that the BSFT program effectively reduced conduct problems and socialized aggression, along with reducing anxiety-withdrawal symptoms. The effects were the strongest on the conduct disorder scale, where 81 cases that were above clinical levels at intake, in which 47% made reliable improvements. The effects were weaker for socialized aggression with 37 cases that started the intervention at clinical levels, with 24% showing reliable improvement and 12% terminated at non-clinical levels. Twenty-nine percent (n-19) of the 65 cases with clinical levels of anxiety-withdrawal symptoms at intake made reliable change with 16 of the cases returning to non-clinical levels. Both parents and adolescents reported significant changes in family functioning over the course of intervention, with parent reports being somewhat stronger than effects for the adolescent reports.

When the effects of the program were analyzed on intermediate outcomes by ethnicity, the results indicated that there were relatively stronger effects for conduct disorder, anxiety-withdrawal, and family functioning. A weaker effect for socialized aggression was found within the Hispanic group. On the contrary, the African American group showed comparable program effects across problem behaviors (conduct disorder, social aggression, and anxiety-withdrawal), but a moderate effect for family functioning. In the last area of program effects on ultimate outcomes, analyses concluded that conduct disorder, socialized aggression and family functioning were all statistically significant predictors of initiating drug use in adolescents. Conduct disorder, socialized aggression and anxiety-withdrawal scores showed statistical significance in predicting initiation of substance use at intake and termination. Overall, the results of substance use decreased between intake and termination (Santistebon et al., 1997).

Robbins, Feater, Horigian, Bachrach, Burlew, Carrion, Schindler, Rohrbaugh, Shoham, Miller, Hodgkins, Candermark, and Werstlein (2011) conducted a multisite randomized trial study with multiethnic samples of families. The purpose of the study was to extend research on the BSFT model by examining the effectiveness of the BSFT interventions, compared to treatment as usual (TAU), in community drug abuse treatment agencies with a racially/ethnically diverse sample of adolescent drug users. The researchers hypothesized that the BSFT model would be significantly more effective than TAU in: (a) engaging and retaining adolescents in treatment, (b) reducing adolescent drug use, and (c) improving family functioning (Robbins et al., 2011). The TAU comparison condition varied across participating community agencies, as it included individual and/or group therapy, parent training groups, non-manualized family therapy,

and case management. In the BSFT condition, 97% of the sessions were classified as family therapy, with the adolescent and other family members present, ranging from 1 to 5. The location for BSFT interventions was flexible to the home (52.2%), clinic (45.3%), and school, work, or other (2.5%).

The study included 480 participants, which consisted of the adolescents and their family members. Adolescents were predominately males (n-377) with 104 females. Through self-report identification, the adolescent sample included: 213 Hispanics/Latinos (Hispanics), 148 non-Hispanic Whites, 110 non-Hispanic Blacks (African Americans), 5 American Indians/Alaskans, 3 Japanese/Whites, 1 Persian, and 1 Lebanese. A high percentage of adolescents, 72% to be exact, were referred for treatment from the juvenile justice system. Therapist demographics were also highlighted for the study. There were a total of 49 therapists who were randomized and assigned to either the BSFT (n-20) or the TAU (n-29) groups, to provide clinical services to the study participants. Therapists were 37 women and 12 men, with a mean age of 40.37 years. Therapists included non-Hispanic Whites (n-27), non-Hispanic Blacks (n-9), Hispanics (n-11), Asian/Pacific Islanders (n-1), and other not specified (n-1). The results of the study were analyzed in 3 different areas: (1) engagement and retention, (2) adolescent drug use and (3) family functioning.

The findings of the study varied in the 3 above areas. First, analysis revealed that participants in the BSFT group had lower rates of failure to engage and failure to retain in treatment than the TAU group. There were no significant differences in engagement and retentions between the BSFT condition and TAU by race/ethnicity, confirming that BSFT has significantly higher rates of engagement and retention within each racial/ethnic

group. There were significant main effects of race/ethnicity on engagement and retention, independent of treatment assignment. African Americans were more likely to fail to engage and Hispanics were less likely to fail to engage in comparison with Whites. African Americans were also more likely than Whites to fail to retain. There was a significant difference in the rates of failure to retain between Whites and Hispanics. In comparing engagement and retention across the two conditions, 25% of African American youth retained in treatment in TAU and 50% in the BSFT condition. There were no differences in engagement or retention by gender.

Second, adolescent drug use analysis did not show significant differences in treatment of the trajectories of adolescent self-reported drug use days across 28-day periods. There were 18 participants in TAU and 13 in BSFT condition who were eliminated from the analysis because they did not have any follow-up drug use data. Baseline family functioning and living with both biological parents were associated with lower self-reported drug use across time. There were no statistically significant differences in treatment effects within the engage or retained subgroups. There were no statistical significant differences noted on adolescent self-reported drug use observed by race/ethnicity or gender (Robbins et al., 2011). Last, the median number of self-reported drug use days at 12 months was significantly higher in the TAU than the BSFT condition. There were no significant differences in median self-reported drug use by days by racial/ethnic group or gender, either overall or within treatment groups.

Last, the BSFT intervention was shown to be more effective than TAU in improving parent reports of family functioning. Adolescents in both conditions reported significant improvements in family functioning, as assessed in the subcomponents of

parenting practices and family environment. These findings provide support for the impact of BSFT on parent-reported family functioning but also suggests that TAU may also be having a positive impact on both parents and adolescents reports on family functioning. There were no statistically significant differences between treatment condition by race/ethnicity or gender in both parent and adolescent reports of family functioning. The findings of this research study reiterate the importance of expanding research that specifically examines Black adolescents and their families, if one was to fully understand their experiences in family therapy. A thorough examination of these experiences may be able to shed light on the low engagement and retentions rates in treatment of Black families.

2.4.3 Attachment-Based Family Therapy

Attachment-Based Family Therapy (ABFT) is a brief, empirically supported, family-based, emotion-focused experienced approach designed to treat depression and suicidality in youth (Diamond, 2014). ABFT bases its premises on attachment theory and models of emotional development in childhood and adolescence. A primary assumption of ABFT is that extreme family conflict, hard criticism, low affective attunement, physical or emotional neglect and abuse can rupture attachment bonds (Diamond, Diamond, & Hogue, 2007). Over time, this ruptured attachment and negative family environment inhibit children from developing the internal and interpersonal coping skills needed to buffer against biological vulnerabilities and social stressors that can cause or exacerbate depression, possibly leading to suicidal ideations (Diamond et al., 2007; Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002). ABFT targets adolescent

depression and suicidality by systematically identifying and working to resolve core family conflicts and repairing damaged parent-adolescent attachment.

In doing so, ABFT is organized around 5 treatment tasks: (1) the relational reframe; (2) adolescent alliance; (3) parent alliance; (4) repairing attachment; and (5) promoting autonomy (Ewing, Diamond, & Levy, 2015). Tasks are not the same as sessions, as they may take several sessions to accomplish. The 5 tasks provide therapists with strategies, principles and themes to help accomplish the goals for each task in sessions. Overall, the therapist provides a structured setting with flexibility to help each family navigate with their challenges. Further readings on ABFT can provide thorough information on this manualized family therapy treatment model, as it is beyond the scope of this literature review.

ABFT studies have been demonstrated to reduce adolescent depression and suicidal ideation more effectively than wait-list control treatment as usual (Diamond et al., 2002; Diamond, Siqueland, & Diamond, 2003; Diamond, Wintersteen, Brown, Diamond, Gallop, Shelef, & Levy, 2010; Israel & Diamond, 2012). These studies have concluded that ABFT is effective with the most troubled populations, which include adolescents with comorbid anxiety, severe suicide ideation, a history of multiple suicide attempts and/or history of sexual abuse (Ewing et al., 2015). The main research project was based out of Children's Hospital of Philadelphia (CHOP) in Philadelphia, Pennsylvania, which has a large urban African-American community. The geographical location has allowed ABFT studies to include Black families as participants.

Diamond et al. (2002) examined the ABFT treatment model on adolescents, aged between 13 and 17 years old, who met criteria for diagnosis of major depressive disorder

(MDD). The mean age of the 31 randomized participants was 14.9 years, with 78% being females (n-25) and 69% (22) identifying as African-American. Participants were primarily referred by schools and parents. The majority (80%) of families were single-parent families, with 69% reporting less than $30,000 annual income. Participants reported that in the last 6 months they had heard random gunshots (47%), had family members who were using drugs or alcohol (31%), and had unwanted sexual experiences (19%). Participants were randomly assigned to 12 weeks of ABFT or 6 weeks of a waitlist control condition. Data was collected at baseline (during intake), mid-treatment (6 weeks) and at post-treatment (12 weeks). Some participants were also evaluated 6 months at follow-up.

The findings of this pilot study concluded that participants who were treated with ABFT showed significant decrease in rates of depression, severity of depression, and anxiety symptoms, when compared to the waitlist control condition. ABFT participants also reported significant decrease in hopelessness and suicidal ideas, while increasing attachment to mothers. A clinical improvement in ABFT was achieved by 56% of adolescents by mid-treatment, and only an additional 6% by post treatment. This may imply that ABFT has its greatest impact on depression within the first 6 weeks. On the contrary, a significant decrease in family conflict was notably achieved until the post-treatment assessment at 12 weeks, which suggests that gains in this domain many take longer to produce (Diamond et. al., 2002).

More recently, Diamond et al. (2010) published similar results on ABFT's effectiveness in comparison to enhanced usual care (EUC) for reducing suicidal ideation and depressive symptoms in adolescents. Similarly, the study was conducted as

randomized control trail of suicidal adolescents between the ages of 12 and 17 years. Of the 341 adolescents that were screened for the study, only 66 entered the study for 3 months of treatment. Of those, 70% of the participants were African American. Data was collected at baseline, 6 weeks, 12 weeks, and 24 weeks. These results further confirmed that ABFT demonstrated significantly greater rates of change on self-reported suicidal ideations at post-treatment evaluation and those benefits maintained at follow-up. Retention was also higher in the ABFT group than the EUC (Diamond et al., 2010). Further research needs to focus specifically on African American families highlighting how their social locations may be contributing to their depressive symptoms. To gain a comprehensive understanding of the underlying reasons and/or causes of depression and/or suicidal ideations, it is imperative that researchers understand the complexities around socio-cultural trauma that is experienced in the daily lives of African American families.

2.4.4 Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT) has shown success in working with younger children and their families. PCIT is a 14-20 week, manualized intervention founded on social learning and attachment theories. It is designed for children between the ages of 2 to 7 years of age with disruptive, externalizing behavior problems (Child Welfare Information Gateway, 2012; Eyberg & Robinson, 1983; Thomas & Herschell, 2013; Urquiza & Timmer, 2012). PCIT promotes the idea that through positive parenting and behavior modification skills, the parents themselves can become the agent of change in reducing their child's behavior problems. It incorporates both the parent and the child in treatment to put the two different phases of PCIT in practice. The first phase focuses

on enhancing the parent-child relationship (child-directed interaction- CDI), while the second phase works on improving child compliance (parent-directed interaction-PDI). In PCIT, the final goals entail the parents learning the skills to facilitate positive interactions with their child(ren), while increasing their child(ren)'s pro-social behaviors and decreasing negative behaviors (Eyberg & Robinson, 1983; Thomas & Herschell, 2013; Urquiza & Timmer, 2012)..

Fernandez, Butler, and Eyberg (2011) examined the course and efficacy of PCIT with 18 socioeconomically disadvantaged African American families of preschoolers with disruptive behaviors disorders (DBDs). These disorders included oppositional defiant disorder (ODD), attention deficient hyperactivity disorder (ADHD) and conduct disorder (CD). The participants were divided in two studies, Study A (10 participants) and Study B (8 participants). Inclusion criteria for the two studies were similar, which consisted of an ODD diagnosis determined by the DSM-III-R structured Interview. The ages of the child were 5 to 6 years old with no history of severe physical or mental impairments. Children taking psychotropic medications for behavioral problems (28%) were required to maintain a consistent medication regimen and dosage scheduled for at least one month before enrolling in the studies. Mothers were asked not to alter their child's medication or dosage during the treatment. Children were referred for treatment by pediatricians, child psychiatrists, child neurologists, teachers and day care providers for both studies.

The children in the studies were 16 boys and 2 girls, with a mean age of 4 years and 5 months. All mothers self-identified as Black or African American. Seventeen mothers identified the target child(ren) as Black or African American. One mother

identified the child as Biracial; however, the non-Black parent was minimally involved in the child's care. The custodial mothers included 89% biological mothers and 11% grandmothers with a mean age of 30 years and 6 months. Half of the mothers were single (50%), married (33%), separated (11%), and divorced (6%). Families were paid $50 after completion of the pre-treatment assessment and $50 after completion of the post-treatment assessment. They were also compensated $3.00 for travel (Fernandez et al., 2011). There were different structured interview scales used for the study to measures behavioral symptoms, which can be obtained by referencing to the article.

The preliminary findings of study concluded that the use of PCIT with socioeconomically disadvantaged African American preschoolers with DBDs and their parents shows significant improvements in their children's behaviors. Mothers' reports of their children's behaviors at pre-treatment and post-treatment indicated reliable improvements in behaviors for most (63%) children following treatment. However, only 50% of the treatment completers showed clinically significant change. Examination on maternal parenting stress showed no evidence of change among the African American mothers in the studies. The high levels of parenting stress at study entry did not improve during the PCIT and remained thereafter. The attrition rate was also high, with 50% of the families dropping out of the study, most before the first treatment session.

These findings suggest a strong need for strategies to engage families during the earliest contacts with PCIT. Despite the researchers' attempts to engage minority families in treatment and studying this population with an EBP model, the small sample of the study questions the effectiveness of PCIT with African American families. The researchers also suggested that these outcomes may have resulted from the lack in

addressing systematical factors that contribute to limited resources of parenting stress, such as poverty or discrimination for socioeconomically disadvantaged African American families (Fernandez et al., 2011). Further research needs to examine these areas specifically to address socio-cultural factors that impede on effective treatment for Black families.

2.4.5 Other Studies on Black Families in Therapy

Other qualitative studies have focused on understanding the experiences of African American families in therapy in reference to their levels of engagement in treatment. Hall and Sandberg (2012) utilized a phenomenological approach to explore barriers that the participants overcame to seeking therapy from their perspectives. The study consisted of nine participants (5 males and 4 females), self-identified as African American or Black, who sought marriage and family therapy from a couple and family therapy clinic at a major university in the Northeast region of the US. All participants were over the age of 18 and were previous clients at the university therapy center. The location of the interviews was the university therapy center or their own home, lasting between 60-120 minutes.

In examining the results of the study, several codes and themes emerges from the qualitative data. In overcoming the barriers to attend therapy, there were four major categories that were highlighted. These categories were: (1) family and friends, (2) stigma, (3) accessibility, and (4) confidentiality. The following themes were identified, within each category:

- *Family and friends*: supportive influences and non-supportive influences;
- *Stigma*: personality, openness to needing help, and explorations;

- *Accessibility*: access and affordability;
- *Confidentiality*: receiving information and comfort with the camera (Hall & Sandberg, 2012).

Overall, the most significant barrier to overcome was the stigma attached to therapy. African Americans participating in this study attributed much of their successes in overcoming barriers in therapy to their own individual personality traits, such as resiliency, confidence, having a strong work ethic, being open minded and thinking independently (Hall &Sandberg, 2012, p. 453). Participants reported that having a connection with the university and being employed within the university exposed them to the services that were being offered at the center. Participants also overcame the barrier of cost and finances due to the flexibility of the clinic by providing a sliding fee scale. This suggests that flexibility in costs may be a way to retain and engage Black/African American clients in therapy.

Jackson-Gilfort, Liddle, Tejeda, and Dakof (2001) also conducted research on African American male adolescents in family therapy. The researchers attempted to address the problem of low levels of therapy engagement and participation among African American youth in MDFT. They examined whether and how therapist behavior and content focus within the therapy session influences adolescent engagement into the treatment process. The culturally related content themes of *mistrust, anger/rage, alienation, respect, journey from boyhood to manhood, and racial socialization* were identified to be utilized for the study. These cultural themes were used as they appear salient in scholarly literature and media sources. It has also been suggested that

intervening in these areas can affect positive adolescent development (Jackson-Gilfort & Liddle, 2000).

To be included in the study, the adolescent had to the meet the following eligibility criteria: randomized to receive MDFT; African American; diagnosed with substance abuse or conduct disorder; participated in therapy sessions that were videotaped; and received treatment from an African American therapist. Participants in the study were 18 adolescents between the ages of 12 and 17 years old living in Philadelphia, Pennsylvania. The mean age of the final sample was 15.1 years, with 50% having been arrested in the past 12 months prior to treatment. Of the total participants, 33% were court-ordered to seek treatment, 52% were from single-parent homes and 33% were receiving public assistance.

The results of the study indicated that culturally relevant content themes (listed above) can improve the level of therapy engagement of Black male adolescent clients. This suggests that infusing such themes into the psychotherapeutic process might be one way to provide better treatment services to African American youth. More thoroughly, it appears addressing angry feelings, sense of alienation and feeling about what it means to be a Black man are discussed directly, the adolescent responds with overall increased engagement in the next therapy sessions. The adolescent is a more active participant in treatment, talking freely, exploring feelings and experiences, and showing esteem towards the therapist (Jackson-Gilfort et al., 2001).

On the contrary, the theme of racial identity/racial socialization showed no relationship with engagement. It did not reach “clinical levels” as the topic area was “brought up but ignored.” More important, there was a negative relationship found

between discussion of trust/mistrust theme and adolescent engagement. This topic of trust was never raised in the content of cultural mistrust; however, the theme emerged spontaneously in therapy while addressing high levels of conflict with parents on losing trust in their sons. This study clearly highlights the importance of discussing certain "themes" in treatment for African American adolescents that help initiate positive engagement in family therapy. Further research needs to expand on how these themes can be infused into the treatment process, so that retentions rates of African American families can be reduced significantly, especially for those who seek treatment and drop out prematurely.

Gantt and Greif (2009) conducted a qualitative study focusing on African American single mothers' experiences with raising sons. Their study explored the following questions: (1) what are the experiences of African American single mothers in raising of their sons? and (2) what coping strategies do African American single mothers use in raising of their sons? The sample included 11 African American single mothers who were raising at least one son. Nine of the women were raising one son and two were raising two sons. The sons' ages ranged from 11 to 16, with average mean age of 13.2 years. The mothers ranged in age from 25 to 53 years, with incomes in the $20,000-$30,000 range. All mothers in the study lived in a city in the south-central part of Pennsylvania. The mothers in the study must also have been single for a minimum of 50% of the life of the son. The mothers who had more than one son were asked to describe her experiences with raising all of them during the interviews.

By utilizing appropriate data collection and analysis procedures, the researchers were able to conclude their findings on the phenomenon of the experiences of single

African American mothers raising sons. The findings of this grounded theory study revealed that African American single mothers make use of a number of parenting strategies to assist them in raising their sons. These strategies aim to meet the goals of protecting and promoting growth in their sons. Single African American mothers use the following strategies to protect their sons: (a) shielding from negative influences, (b) avoiding harm, (c) praying, (d) educating, and (e) interpreting. Furthermore, they use other strategies to facilitate growth in their sons: (a) providing social support and connection with fathers; (b) providing resources; (c) setting expectations; (d) instilling a positive African American identity; and (e) promoting responsibility (Gantt & Greif, 2009, p.231). In sum, African American single mothers implement various parenting strategies aimed towards reaching the goals of protecting and promoting growth in their sons.

Similarly, Kelch-Oliver (2011) recognized the importance of understanding the experiences of African American grandmothers as there is an increase in children being raised in grandparent-headed families (GHF). This increase is often associated with a myriad of interrelated family circumstances and social problems existing in today's society (Whitley, Kelley, & Sipe, 2001). These include: child maltreatment, parental substance abuse, poverty, homelessness, and the HIV/AIDS epidemic (Kelley, 1993; Whitley et al., 2001). Urban, low- income, single African American women experience GHF at a significantly higher rate than any other racial or ethnic group (Caputo, 2001; Jimenez, 2002; Whitley et al., 2010). As the needs of GHF are unique and complex, it is important to understand their experiences thoroughly from their perspectives. The aim of

this qualitative study was to explore the experiences of African American grandmothers who were the primary caregivers of their grandchildren.

The demographics of the grandparent participants were as follows: there were 6 African American grandmothers who were interviewed; 5 grandmothers were maternal with one great grandmother, who was raising her son's grandchildren; 5 out of 6 were single (divorced, separated or never married), and one grandmother who was married. The grandfather was not included in the study as he was not involved with the primary caregiving responsibilities. In reference to number of children in the household of the 6 grandmothers, 3 grandmothers were parenting 1-2 grandchildren, 3 grandmothers were parenting 3-4 grandchildren, and no grandmothers were parenting 5 or more grandchildren. Two of the grandmothers reported raising their children for less than 5 years and 4 grandmothers had been long-term caregivers for 5 or more years. The grandchildren's age ranged from 10 to 16 years.

The range of the grandmothers' age was from 45 to 69 years, with one grandmother from 45-55 years, three 55-65 years, and two were 65+ years. The average age was 55 (5 out of 6 grandmothers). The majority of the grandmothers lived below poverty level (lowest $10,000 to highest $35,000). They received other sources of financial assistance as income, including relative foster care/adoption assistance, social security for disability, social security, retirement/pensions and governmental assistance (i.e. Temporary Assistance for Needy Families, TANF). Last, the reasons the grandmothers took over the responsibility of caring for their grandchildren were: parental substance abuse, which resulted in neglect or abuse; medical illness; mental/psychiatric

illness; death of mother; teenage pregnancy; and/or eviction/housing problems. The most common reason mentioned for caregiving was substance abuse (Kelch-Oliver, 2011).

Kelch-Oliver's (2011) phenomenological study identified the following major themes from the interviews that were conducted with the grandmothers: (a) grandparent's roles/caregiving responsibilities, (b) loss of independence/changes in quality of life when assuming caregiving, (c) ways of coping with caregiving situation, (d) future goals for grandchild(ren), and (e) advice to other grandparents who are raising their grandchildren. The present results of the study indicated that these grandparents experience the normative adjustment issues associated with parenting for the second time around, which consists of changes in quality of their lives. With these changes, they also reported a newfound purpose and meaning, as well as pride in rescuing grandchildren from the foster care system and maintaining family continuity. The grandmothers' experiences were characterized by both challenges and rewards. More specifically, consistent themes of single parenthood, fatherlessness, and implications of these family structures in the grandparent/grandchildren's lives were noted (Kelch-Oliver, 2011). Future research should focus on the experiences of these grandchildren being raised in GHF in which their parents are not involved.

2.5 Theoretical Frameworks

This research study utilized the theoretical frameworks of Narrative theory, Africana womanism theory, along with incorporating tenets of the MCP (Hardy & Laszloffy, 2002; Hudson-Weems, 1993; White & Epston, 1990). A discussion of the four aggravating factors (devaluation, disruption/erosion of community, dehumanization of loss, and rage) of adolescent violence will also be addressed. These factors will provide a

unique understanding of how societal injustices, such as racism, sexism, classism and other -*isms* impact the experiences of Black adolescents from underserved communities (Hardy & Laszloffy, 2007).

2.5.1 Overview of Narrative Theory

Narrative theory is recognized as a philosophical, theoretical and therapeutic approach (White & Epston, 1990). It is based on Psychologist Jerome Bruner's (1990) view that humans give meaning to their lives in a socially constructed world by organizing their life experiences in a narrative form (Bruner, 1991; Hannen & Woods, 2012). Bruner (1990) suggested that within our selection of stories expressed, there are always feelings and lived experiences that are left out of the dominant story (Bruner, 1991; Madigan, 2011). Narrative theory is organized with the central idea that the stories people tell and hold about their lives often determines the significance they give to specific life events (Madigan, 2011). Narrative theory is based on the premise that, "there are no events that we, as individuals, can comprehend objectively and...….we all have stories about these events" (Hoffman, 1993, p. 106).

Narrative theory focuses on the psychological problems clients experience, that emerge from conflict between the culturally determined narrative structures they have been using to conceptualize their lives and their actual-lived experiences (Young, 2010). Those culturally determined narratives need to be revisited to fully capture the individuals' and families' experiences. Hence, Narrative theory helps individuals and families overcome persistent problems by revising the client's self-representation, or life story, to emphasize previously unrecognized strengths, or *unique outcomes* (White & Epston, 1990; Young, 2010). Stories consist of events that are linked in sequence, across

time, and in accordance to a specific plot, which forms a dominant story, also called a narrative (White, 2007; Morgan, 2000). Therefore, Narrative theory allows an individual to describe and interpret how he/she is storying his/her world, what the meaning of this is for him/her, and then help him/her reauthor an alternative, that is a more positive, helpful story (White & Epston, 1990; White, 2007; Morgan, 2000).

The Narrative theory approach essentially focuses on the deconstruction of dominant stories about a problem, with the aim of developing a more empowering self-narrative (White & Epston, 1990). The most valuable aspect of Narrative theory is the emphasis on externalization of the problem so that the individual can develop new strategies for dealing with the problem that eliminates self-blame, while enhancing self-esteem (Bennett, 2012). In doing so, the underlying assumption is that people's experiences of the problems are shaped by stories, that are constructed and influenced by individuals' social locations in certain groups (Combs & Freedman, 2012). Narrative theory encompasses four main components that allow individuals to begin developing a more positive story. These include: (1) deconstruction of the dominant story, (2) externalizing the problem, (3) identifying unique outcomes , and (4) and reconstruction and/or reauthoring of story (Carr, 1998; Morgan, Brosi, & Brosi, 2011; White, 2007; White & Epston, 1990).

Deconstruction of the Dominant Story

Narrative theory holds the perspective that problems only survive and thrive when they are supported by particular ideas, beliefs, and principles (Morgan, 2000). The process of *"deconstructing"* entails discovering, acknowledging and "*taking part*" in the beliefs, ideas and practices, of the broader culture in which a person lives that contribute

to the problem and the problem story (Morgan, 2000, p. 45). Deconstruction simply means examining assumptions so that new meanings can be created (Nichols & Schwartz, 2006). Through the process of "*deconstructive listening*," Narrative theory seeks to open space for aspects of people's life narratives that have not yet been storied (Freedman & Combs, 1996). Listening "*deconstructively*" to people's stories is guided by the belief that those stories have many possible meanings, which allows for the construction of new positive stories that are meaningful (Freedman & Combs, 1996). Deconstruction can challenge previously "*taken-for-granted*" ideas that lead to alternative stories allowing people to break from the problem-saturated view. Deconstruction allows people to connect with their preferred ideas, thoughts and ways of living (Morgan, 2000).

Externalizing the Problem

"*Externalizing*" is an approach that encourages persons to objectify and/or personify the problems that they experience as oppressive (White & Epston, 1990; White, 2007). The process of revising narratives involves exploring the problem and recognizing that the conflict between the narrative and experience is outside the self (Young, 2010). Externalizing the problem causes the individual's life experiences to emerge as "*unique outcomes*," which are separate from the person's identity from the problem for which they seek assistance (Morgan, 2000; Nichols & Schwartz, 2006; White, 2007). Instead of *having* a problem or *being* a problem, Narrative theory allows for individuals to think of themselves as struggling *against* their problems. Neither the individual nor family is the problem; the problem is the problem (Nichols & Schwartz, 2006; Morgan, 2000; Freedman & Combs, 1996). Narrative theory "*externalizes*" problems from persons,

mainly to deconstruct the disempowering assumptions that often surround problems stemming from negative internalized messages about the self (Nichols & Schwartz, 2006). It also creates opportunities to "name the problem." Externalizing the problem allows individuals to become free from the disabling effects of the named problem by separating it from the client (individual), hence giving a sense of self-empowerment, liberation and control (Morgan et al., 2011; White, 2007).

Identifying Unique Outcomes

Discovering and identifying *unique outcomes* is also a main concept in Narrative theory. This entails hearing events that fit the dominant problem-saturated story, while highlighting events that contradict or stand outside of that dominant problem story (Morgan, 2000). These events are called unique outcomes or "sparkling events" as they shine and/or stand out in contrast to the dominant story (Morgan, 2000; Nichols & Schwartz, 2006; White, 2007). Unique outcomes can serve as doorways to alternative stories. A unique outcome can be a (an): plan, action, feeling, statement, quality, desire/dream, thought, belief, ability and commitment. They can also be in the past, present and/or the future (Morgan 2000). It is important to note that these events need to be readily recognized as unique outcomes as they serve the foundation to move forward with any interventions that bring change. It is often difficulty and merely impossible for individuals to recognize these unique outcomes, as they are often emerged in many negative cognitive distortions that perpetuate their dominant stories. These sparkling events open doors to a new and different conversation, which allows individuals to move towards richer descriptions of their stories (Morgan, 2000).

Reconstruction and/or Reauthoring

Reauthoring conversations are a crucial part of both the philosophical underpinnings of Narrative theory as well as the practice work itself (Madigan, 2011). Reconstructing and reauthoring of stories involves the use of many narrative techniques and/or methods. The techniques of deconstruction of dominant stories, externalization of problems, and identification of unique outcomes, all create space to reconstruct and reauthor individuals' narratives. "*Reconstruction*" is easily understood by replacing the problem-saturated story with one that allows the person to be successful despite the constraining factors in their lives (White & Epston, 1990). This is called the *"alternative story*," the exception. Just as there may be different problems to externalize, there are also a variety of alternative stories. Alternative stories began with noticing and exploring the significance of the unique outcomes and how those continue to create a non-problematic story or narrative (Morgan, 2000).

Overall, Narrative theory is predicated on the belief that individuals' identities are socially constructed and further reinforced by society (White & Epston, 1990). Narrative theory supports the idea that change takes place in individuals by deconstructing and/or resisting the cultural and social values that create the problem-saturated stories that individuals tell themselves (White & Epston, 1990; Young, 2010). Narrative theory allows individuals to work against the problematic dominant story to confront the cultural norms that form its foundation. Narrative theory creates space for individuals to embrace revised narrative(s) that are authentic and meaningful to them.

2.5.2 Overview of Africana Womanism Theory

The paradigm of African womanism has its foundations in the dissimilarities between women of African descent and those of European origins (Ntiri, 2001). According to Hudson-Weems (1998), African womanism is:

> An African-centered ideology created and designed for all women of African descent. It is grounded in our culture and therefore, it necessarily focuses on the unique experiences, struggles, needs, and desires of African women. It critically addresses the dynamics of the conflicts between the mainstream feminist, the Black feminist, and the Africana womanist. The conclusion is that Africana womanism and its agenda are unique and separate from both White feminism and Black feminism, and moreover, to the extent of naming in particular, Africana womanism differs for African feminism. (p. 24).

Hudson-Weems (1998) makes an obvious distinction between Africana womanism and other feminist ideologies. The feminist movement evolved from its initial thrust to addressing women's civil rights and social injustice following slavery to sexual parity in the US. It also focused on worldwide concerns of sex discrimination of women in a world of male power and privilege. Because of its exclusion of other important issues, such as race, class and gender, the feminist movement resulted in the alienation of women of color (Ntiri, 2001, p. 163).

African womanism is family-centered, whereas feminism is female-centered. The priorities of African womanism are race, class and gender as it strives for race empowerment, whereas feminism concentrates primarily on gender issues and strives for female empowerment (Hudson-Weems, 2001). Feminism centers and makes problematic

women's diverse situations and the institutions that frame those situations, such as equal wages in the workplace (Creswell, 2007). Dissimilarly, the basis for Hudson-Weem's theory, African womanism, is the assumption that race is the paramount importance in any deliberations of or about African women. Therefore any discourse involving Africana women (people) cannot escape the historical realities of Eurocentrism, oppression and domination, which makes sense to articulate a clear and firm position that is inclusive of those realities (Ntiri, 2001).

Other scholars, such as Bettina Aptheker (1981), analyzed the basic difference between Black and white women as she recognized that the first order for Black women and their communities is to address the race factor (Hudson-Weems, 2001). Her assessment of the situation entailed the following:

> When we place women at the center of our thinking, we are going about the business of creating an historical and cultural matrix from which women may claim autonomy and independence over their own lives. For women of color, such autonomy cannot be achieved in conditions of racial oppression and cultural genocide…. In short, "feminist," in modern sense, means the empowerment of women. For women of color, such an equality, such an empowerment, cannot take place unless the communities in which they live can successfully establish their own racial and cultural integrity. (p. 19).

If a Black woman chooses to identify herself as a feminist, whether she is African or African American, then gender automatically takes the center stage, not race. To claim feminism, then, is to suggest that gender oppression is the primary issue in the Black community. This in turn violates certain African American community rules and

undermines the collectivism necessary to struggle against the group's oppression (Ntiri, 2001). Despite the theme of domination prevailing in the feminist literature as well, the subject matter is still gender domination within a patriarchal society, not racial domination (Creswell, 2007). It is clear that addressing race issues for Black women is a prerequisite for addressing gender concerns (Hudson-Weems, 1998, 2001).

Patricia Hill Collins has taken a stance similar to Hudson-Weems (1998) and Aptheker (1981). Collins (1996) argues that some of the characteristics of white feminism are in conflict with the moral ethos of oppressed people whose past is marred by the collective actions of the oppressor group (Ntiri, 2001). In solidifying her argument, Collins makes the following three points: (1) gender works with racism to maintain oppression, (2) an acceptance of feminism by Africana women translates into the rejection of African men given the theoretical underpinnings of the movements, and (3) the practice of feminist ideology is based on individualism rather than communalism lifestyles and values that are more akin to African American's and their ancestry (Collins, 2001; Ntiri, 2001).

These ideas and concepts are also congruent with the work of Linda LaRue (1970) and Audre Lourde (1984). They all recognize the differences in the specific struggles of Black women versus white women, who do not have the burden of racial oppression. LaRue (1970) voices her positions by highlighting the following distinction of white male domination relative to Black men and women versus white women: Blacks are *oppressed* and that means unreasonably burdened, unjustly, severely, rigorously, cruelly and harshly fettered by white authority. White women, on the other

hand, are only *suppressed*, and that means checked, restrained, and excluded from conscious and over activity. And this is the difference. (p. 218)

These concepts are highly relevant to this study as the researcher examines the experiences of African American adolescents in family therapy in the contect of race, gender, class and age.

2.5.3 Overview of the Multicultural Perspective

The MCP was also integrated as a meta-framework for this transcendental phenomenological study. Hardy and Laszloffy (2002) define the MCP as:

> A worldview, an epistemological stance that involves how we (individuals) view the world, but more importantly, how we place ourselves in the world. It promotes an understanding of the "other," understanding of the "self," and especially, an understanding of the "self in relation to the other." It is a philosophical stance that significantly informs how one sees the world both inside and outside of therapy. (p.569).

The MCP is shaped by several assumptions, one of which is that *culture* is a complex, fluid and dialectical concept (Hardy & Laszloffy, 2002). Culture is defined as a broad-based multi-dimensional concept that shapes individuals' attitudes, norms, beliefs, values and behaviors (Hardy & Laszloffy , 1995; Hardy, 2008; U.S. Office of the Surgeon General, 2001). It refers to the shared attributes of one group or subgroup often describing a system of shared meaning (U.S. Office of the Surgeon General, 2001). Culture is multi-layered and comprised of numerous dimensions, such as race, ethnicity, gender, social class, religion, age and sexual orientation (Hardy & Laszloffy , 1995; Hardy, 2008). These dimensions, along with many others, contribute to forming an

individual's cultural identity, which ultimately impacts how individuals view the world. It is the intricate interaction between and among these dimensions, as well as how each informs the others that ultimately shape how an individual defines oneself (Hardy & Laszloffy, 2002, p. 569). Overall, culture has a major influence on how individuals' experience, understand, express, and address emotional, behavioral and mental distress (Pumariega et. al, 2005).

Another assumption that is embedded within the MCP is that *context* is significant and reality is relative. Context refers to the "sense of embeddedness that we all have that helps define the nature of our existence" (Hardy & Laszloffy, 2002, p. 571). The nature of our existence is defined by the various experiences and perspectives that we encounter in our daily lives. Context and reality both play an essential role in the communication that occurs cross-culturally and the meaning that is developed, received and/or perceived (Hardy& Laszloffy, 2002). There is a virtually inextricable relationship between context and reality, in that context shapes our reality and it defines and punctuates the meanings we attached to our lives (Hardy & Laszloffy, 2002).

The MCP places significance on context, as it recognizes the salience of the familial context as a major meaning-making marker of one's subjective experience (Hardy & Laszloffy, 2002). The MCP posits that each of us has multiple selves that are embedded in and defined by multiple contexts (Hardy & Laszloffy, 2002). Hence, understanding the experiences of lower-income Black adolescents in family therapy in a RT, in the context of race, gender, class, and age, within the residential culture is essential in gaining a thorough understanding of their lived experiences.

2.5.4 Dominant Narratives of Youth in RTFs

In *Teens Who Hurt*, Hardy and Laszloffy (2005), discuss four aggravating factors that contribute to adolescent violence. These include: (1) devaluation, (2) disruption/erosion of community, (3) loss, and (4) rage. Most youth entering residential care have an extensive history of trauma, violence, abuse and/or loss that have impacted their ability to live productive lives. These disturbing histories lead to further victimization of self and others. Over time, these youth become a "menace" to society as they have engaged in dangerous, violent behaviors at home, in school and/or in the community. The four aggravating factors can help understand the experiences of Black adolescents who are admitted to RTFs through a socio-cultural perspective (MCP discussed above).

Devaluation

The first aggravating factor associated with adolescent violence is *devaluation*. Hardy and Laszloffy (2005) define devaluation as "a process that strips a person or a group of dignity and a sense of worth…. devaluation is like an untreated cancer that attacks deep inside one's core, as it slowly eats away at one's sense of self-esteem, and often does so unbeknownst to the affected individual and group" (p. 35). Devaluation contributes to the wholesale decay of one's sense of dignity and assaults the core of one's being in a way that highlights the significance of one's insignificance and worthlessness (Hardy & Qureshi, 2012). Undoubtedly, it is safe to say that virtually everyone has experienced devaluation at some point in their lives. Even those who hold power in privileged positions are exposed to experiences of devaluation in other subjugated

positions. The emotional wounds inflicted by devaluation that largely go untreated and unhealed leave a crippling emotional effect (Hardy & Laszloffy, 2005).

Devaluation can occur as a result of situational and/or societal forces (Hardy & Laszloffy, 2005). The situational forces are mainly comprised of experiences and/or circumstances that are unique to a given individual, happen by chance and are not necessarily systemic or targeted towards specific groups (Hardy & Laszloffy, 2005; Hardy & Qureshi, 2012). Societal forces are less idiosyncratic and tend to be pervasive and systemic as they target groups of people (Hardy & Laszloffy, 2005; Hardy & Qureshi, 2012). For minority youth, they are largely impacted by societal forces that affect their ability to refrain from self-destructive behaviors, when the most prominent dominant stories in their lives consist of repeated experiences of devaluation on the basis of their social location in a marginalized group(s), such as race, gender, class, sexual orientation, age and/or religion (Hardy & Laszloffy, 2005; Hardy & Qureshi, 2012). It is also highly conceivable that one individual can simultaneously suffer from both situational and societal devaluation (Hardy & Laszloffy , 2005).

Disruption/Erosion of Community

The *disruption/erosion of community* is the second aggravating factor underpinning adolescent violence. Among adolescents who become violent, the disruption/erosion of community is almost evident. Hardy and Laszloffy (2007) define *community* as:

> A place where adolescents feel a sense of belonging and connection with others in a special way. It's a place where they can learn about who they are. It's where they begin to develop a sense of identity and a vision of how they *fit* in the world

> around them. Community is a place where adolescents can find answers to life's many difficult and complicated questions. It is a place where adolescents find comfort when they are overcome with despair, a place where they feel accepted" (p. 63)

Community, as defined by Hardy and Laszloffy (2007), provides adolescents with a sense of safety, security and meaningful relatedness with others. It further emphasizes both tangible (physical dimension) and intangible needs (emotional, psychological and spiritual dimensions). More concretely, the intangible dimensions of community involves recognizing *feelings*- feelings of belonging, rootedness, identity, connection, safety, security, familiarity, caring and hope (Hardy & Laszloffy, 2007, p. 63).

Overall, community buffers against the trials and tribulations of life for adolescents, as it fosters resiliency when one is faced with adversity. It creates a place to nurture pro-social qualities such as compassion, caring, cooperation, collaboration and conscience. It is a place that adolescents can call "home," which in turn creates a context to counteract devaluation that is experienced by youth (Hardy & Laszloffy, 2007). In the absence of community, adolescents are more vulnerable to the trauma of devaluation. The disruption/erosion of community in the lives of youth can, in and of itself, constitute a form of devaluation (Hardy & Laszloffy, 2007).

Disruption/erosion to the community can occur at three different levels: primary, extended, and cultural communities. Primary communities include families, as defined by the individual. Extended communities include neighborhoods, schools, churches, community centers, civic groups and so forth. Extended communities are mostly connected by physical locations at local levels. The third level consists of cultural

communities, which refers to communities that adolescents have membership in on the basis of their race, gender, social class, sexual orientation, mental/physical ability and religion (Hardy & Laszloffy, 2007). Cultural communities have the greatest impact on adolescents as they have *intangible* borders, that do not necessary allow individuals to choose their social locations (Hardy & Laszloffy, 2007). Cultural communities are most significant in the lives of adolescents, as a high level of socialization occurs within the cultural context. It is through this level of community that we, as human beings, get acutely acquainted with ourselves through the prisms of race, gender, social class, ethnicity, religion, etc. (Hardy & Laszloffy, 2007, p. 67).

For adolescents who engage in violent behaviors, disruption/erosion of community may have occurred in one, two, or all three levels of communities. The forces that disrupt their communities, specifically their home, exist in many forms. Primary communities are disrupted by experiences with abuse, neglect, separation or divorce and/or death within the family. Extended communities can be disrupted by external and internal factors, such as poverty, natural disasters, lack of accessibility to economic resources (i.e. educational opportunities, closing of schools due to funding cuts) and bullying at school, all of which threaten ones sense of safety and security. Last, cultural communities are disrupted by forces of racism, sexism, classism, anti-semitism and more. An individual's social location in any subjugated group may contribute to disruptions in the cultural communities (Hardy & Laszloffy, 2007).

Dehumanization of Loss

The third aggravating factor for adolescent violence is the *dehumanization of loss*. Individuals experience loss at different times of their lives. Unfortunately, for some

people, their dominant narratives consist of repeated experiences with loss. Individuals can experience *tangible* and *intangible* losses. Intangible loss occurs primarily in the emotional and psychological domain, as it entails loss of respect, dignity, hope, voice, and other areas that are impalpable (Hardy & Laszloffy, 2007). Tangible loss has a physical and an emotional, psychological component, such as the death of loved one. Tangible loss is characterized by losing something physically, which also impacts one's emotional and psychological well-being, which is intangible (Hardy & Laszloffy, 2007). Adolescents experience ten different types of losses. These include: (1) loss of a hero, (2) loss of romantic relationship, (3) separation and/or divorce of parents, (4) abandonment or death, (5) neglect, (6) loss of the sense of physical safety, (7) moving to a new area, (8) loss of friendships (not related to moving away), (9) loss of diminished function, and (10) loss of economic security (Hardy & Laszloffy, 2007, p. 81-90).

Adolescents who resort to violence are especially susceptible to having their experiences with loss have go unrecognized or "dehumanized." Dehumanization of loss simply means that loss has not been acknowledged by others. Loss becomes more painful when it remains unmourned and unacknowledged (Hardy & Laszloffy, 2007). Dehumanization of loss hinders the healing process and it impedes on healthy emotional development. Repeated experiences with unacknowledged, unmourned and unhealed losses contribute to dehumanization of loss, which is a precursor to violence (Hardy & Laszoffy, 2007). When loss is dehumanized, it is stripped of its meaning. The lack of the recognition of the loss(es) set(s) the stage for adolescents to utilize violence as an anesthetic for their pain and suffering. To cope with the devaluation of their losses,

adolescents turn to self-destructive behaviors, such as violence, substance abuse and self-injury (Hardy & Laszloffy, 2007; Hardy & Qureshi, 2012).

Rage

The last aggravating factor relating to adolescent violence is *rage*. The four aggravating factors discussed here are connected, with rage being the last-step before violence occurs. Devaluation often contributes to the disruption/erosion of community and vice versa. Devaluation and the disruption/erosion of community are forms of loss, and when losses remain unacknowledged, this further contributes to a sense of devaluation. An accumulation of one's experiences with devaluation, disruption/erosion of community and dehumanization of loss increase the risk of violence. Important to note here is that not all four aggravating factors are of equal weight, as the presence of the first three contribute to the last one (Hardy & Laszloffy, 2007).

Rage is defined as a natural and healthy response to pain and injustice, as it is a normal emotional reaction to the pain and suffering that occurs as a result of experiences with devaluation, disruption/erosion of community and dehumanization of loss (Hardy & Laszloffy, 2007). It is the suppression and denial of rage that constitutes a problem, as adolescents are deprived of the opportunities to channel their rage more constructively (Hardy & Laszloffy, 2007). Over time, the likelihood that suppressed rage will be transformed into violence increases drastically. The lack of healthy expressions only intensifies rage, which ultimately leads to violent behaviors and consequences. Hardy and Laszloffy (2007) discuss three dimensions and/or manifestations of rage: (1) explosive, externally directed rage; (2) silent, externally directed rage; and (3) internally directed rage. Explosive, externally directed rage is the most obvious to the naked eye, as it

involves incidents of yelling, screaming and physical aggression towards others. Silent, external directed rage is more subtle as it is a quiet rage that smolders just beneath the surface. It is only a matter of time before the individual explodes and acts on that rage, when the opportunity arises. Last, internally directed rage is turned inwardly, leading to self-destructive behaviors such as cutting and/or substance abuse (Hardy & Laszloffy, 2007; Hardy & Qureshi, 2012).

These aggravating factors set the stage for understanding the experiences of Black adolescents in RTFs. As discussed previously, most youth who are admitted to residential care have exhausted all other forms of treatment interventions. They have failed to succeed in society and are deemed unsafe to remain in the community. They are removed from their communities and placed in restrictive settings. These youth are taken away from their primary, extended and cultural communities and placed in a restrictive setting with stringent rules and regulations (Hardy & Laszloffy, 2007). The disruption/erosion of community that takes place in the lives of these youth exacerbates their experiences with devaluation, especially as it often goes unattended or unacknowledged. The dehumanization of the tangible and intangible loss that is experienced by the youth (by being removed from their homes) may contribute to increased behavioral and emotional challenges in the RTF. This loss is mostly unacknowledged, which allows for the continuation of the youth to remain labeled as "troubled." The increased behavioral problems of the youth (as a result of the loss) are further used to justify the need for the youth to remain in the RTF for a longer period of time.

This Literature Review has provided detailed information on the complexities that exist with youth who are involved and treated in different SOC. Unfortunately, the

dominant narratives of youth in RTFs revolve around their extensive histories of trauma, loss, abuse, and neglect. These dominant narratives have damaged their sense of self, as they have come to understand their existence as inhumane (Hardy & Laszloffy, 2007). They are repeatedly judged on their social locations in subjugated groups and rarely given the "benefit of the doubt" that their privileged peers receive (hardy & Laszloffy, 2007). These societal divisions, in itself, contribute to experiences with devaluation.

It is the assumption of this researcher, who has worked as clinical therapist in a RTF, that treatment lacks a multicultural perspective. To begin the healing process for underserved families, it is essential to incorporate interventions that allow them to openly engage in a dialogue about their experiences with devaluation, disruption/erosion of their communities, and dehumanization of the losses that they have experienced repeatedly. Hardy & Laszoffy (2007) have provided effective strategies in addressing the problem of adolescent violence in *Teens Who Hurt*. To target societal problems of adolescent violence, they have developed the VCR (validate, challenge and request) approach and the PTA (parents, teachers and adults) rule. A thorough discussion of the VCR approach and PTA rule can be found in their book. In short, these two main strategies will create an opportunity for systemic, long-term, change to take place and reduce adolescence violence by counteracting devaluation through validation and rehumanizing of loss. Restoration of the community is also imperative and can be invoked by the PTA rule, which focuses on the larger cultural community working together to bring about social change (Hardy & Laszoffy, 2007).

The experiences of Black youth in the RTF cannot be fully understood without examining their experiences through a socio-cultural lens. The MCP framework helps

conceptualize the socio-cultural contexts in which these Black youth experience their daily lives. As their lives are embedded with experiences with devaluation, disruption/erosion of community and dehumanizing loss, it is safe to assume that underprivileged youth are at a higher risk for resorting to violence. As devaluation can occur in the context of one's race, gender, class, age and other variables, rage is inevitable. For youth who are targets of racial discrimination and economic deprivation in all SOC, both micro and macro, violence seems to be the only outlet. Reoccurring incidents of violence lead to safety concerns, which in turn, create a pathway for being admitted to a RTF. It is important that collaboration takes place within all SOC (communities), who are involved in the youth's care, to understand these complexities, to evoke permanent change.

2.5.5 Gender and Devaluation

As this study examined the experiences of Black adolescent females in family therapy, it is noteworthy to address the experiences of Black females and devaluation. Females experience societal devaluation on the basis of their gender, which is not experienced by males. It is merely impossible to discuss issues around gender inequality without addressing the role of women in today's patriarchal society. As adolescent females work towards developing a strong sense of self, they receive both implicit and explicit messages that highlight the importance of focusing on their physical appearance, beauty and sexuality (Hardy & Laszloffy, 2007; Wolf, 1997). The interaction between gender and race makes for an even more complex experience of devaluation for Black females due to social positions in two subjugated groups (Hardy & Laszloffy, 2005).

The patriarchal culture in the US has set certain standards of physical beauty which has constituted the defining features of female worth that clearly cannot be achieved by females of color. For a female to be deemed beautiful and desirable in mainstream U.S. society, she must be white, thin, with large breast and a flat stomach, and ideally with silky blond hair, blue eyes, and narrow, angular facial features (Hardy & Laszloffy, 2005). These traits are difficult for any female of color to attain, hence devaluing their self-worth. It is tremendously difficult to build a strong self-identity, even with all the right support systems in place, as an adolescent.

Naomi Wolf's (1997) work on female sexuality provides clarity on the intersection of race, gender, and sexuality that make the experiences of Black females with devaluation more vivid and intense. Boys receive messages about their blossoming sexuality as a source of pride- a vigorous, exquisite, healthy need that should be honored, catered to, and nurtured (Hardy & Laszloffy, 2007). On the contrary, girls receive messages that suggest that their emerging sexuality is a source of shame. Wolf (1997) describes this clearly:

> Every day, one of us adolescent girls might here in a conversation in the school yard, or on the street, these words: "cunt," "fuck," "pussy," "whore," "bitch," and of course "slut." We shrugged them off again and again but always felt as if a small stain from them clung to us, a show of dirt. Of course, we knew the words were about us, our bodies, our wishes. If we consider the slang terms that describe female sexual anatomy, the veil of ugliness through which our culture sees women's sexuality is all too obvious. Many have noted that the words tend to connote, at their worst, wound; at best, receptacles. Not one slag term- or formal

> term, for that matter- about women that we girls heard encoded the idea of value or preciousness. (p. 182).

Hardy and Laszloffy (2007) expand on Wolf's (1997) work in their book *Teens Who Hurt:*

> As females journey towards womanhood, they are exposed to a multiplicity of messages that convey a profound disrespect for femaleness, in general, and female sexuality, more specifically. At best, females experience their developing bodies as a joke, a source of crude locker room humor. At worst, they experience their bodies as license for other (specifically males) to abuse, exploit, and violate them. Their emerging desire is a source of profound devaluation that transcends the generalized devaluation that affects all females. (p. 50).

The challenge of developing a strong self-identity is exacerbated for females of color, due to internalized societal messages that they will never be "them" because of their skin color, eye color, hair texture and other physical traits. Watson (2013) describes this as "*the myth of Black inferiority.*" The myth of Black inferiority is defined as:

> The internalized belief that Blacks are less worthy than whites, which impacts how we think about ourselves, how we perceive one another and our sense of unity in the Black community. It underscores all our relationships and has been passed down from one generation to another by both Blacks and whites, as it damages an individuals' self-identity. (p. 33-34).

As mentioned previously, developing a strong sense of self-identity is very important during the adolescent years. For Black adolescent females, this is merely impossible as they battle with the negative messages that society has portrayed on them. Their journey

into womanhood is marked with further unjust experiences of devaluation, relating to race and gender. Black females' struggle with their sexuality is further intensified as they battle with the "labels" left-over from the residual effects of slavery (which are discussed below). The way they relate to themselves, their fundamental sense of self-esteem, self-worth, self-confidence, self-evaluation and ability to trust, overall their self-concept has been profusely damaged (Watson, 2013). As these Black adolescent females continue their journey into womanhood, they face additional struggles in solidifying their self-identities.

2.5.6 Three Masks for Black Womanhood

Historically, Black women have had to endure the suffering of many negative labels (Boyd-Franklin, 2003). They have been stereotyped as promiscuous, aggressive and domineering (Boyd-Franklin, 2003; Hudson-Weems, 1993). The horrific effects of slavery have forced Black women into one of the following three roles: (1) mammy, (2) sapphire and (3) jezebel (Watson, 2013). Mammy is the "strong (matriarch) Black woman," sapphire is the "angry (bitchy) Black woman," and jezebel is the "slutty (overly sexualized) Black woman" (Hudson-Weems, 1993; Watson, 2013). Black women in general and dark-skinned Black women in particular are associated with one of these unflattering categories (Watson, 2013, p. 89).

These above labels shed a negative light on Black females, which impacts their lives in many aspects. In examining the family dynamics with the Black female population that will be examined in this study, these above internalized messages of "being bitching/angry, slutty and independent," (which translates into not needing protection and support), continue to be passed down from one generation to generation,

both through the family and the community. These subjugated experiences with racism and sexism in the society create a context for Black women to internalize messages of devaluation, which later trickle down to the female off-springs.

2.5.7 Significance of Theoretical Frameworks to the Study

In order to thoroughly understand the appropriateness and rationalization of utilizing Narrative theory, Africana womanism theory, and the MCP for this research study, it is essential to highlight the dominant narrative(s) of youth residing in the RTF. The researcher of this study as had the opportunity to work alongside with youth, families and other third parties involved in the youth's care. These experiences have allowed for a unique personal, professional and most importantly, clinical perspective. As previously stated, Narrative theory focuses aggressively on the dominant narrative(s) of individuals, specifically those that are imbedded with internalized messages of self-hate. Most often, internalized messages of self-hate stem from repeated unjust experiences of oppression, discrimination, and/or subjugation, leading to the dominant narrative of devaluation. Experiences with devaluation solely occur in the context of one's subjugated position in different groups, and in relation to others who hold privileged positions.

As a result of unjust, repeated experiences with devaluation, the damage that is often inflicted on the self-esteem of urban African American/Black youth is profound and deep-seated (Hardy &Laszloffy, 2005; Hardy & Qureshi, 2012). Encouraging and constructing a positive self-esteem and racial identity is noted as one of the greatest concerns for Black parents, who are raising youth in the US today (Boyd-Franklin, 2003). This task has been made relatively difficult due to exposure to negative images or

caricatures of Blacks on television and other types of mass media, which implicitly and explicitly devalues them (Boyd-Franklin, 2003).

The concepts of Africana womanism also align with the objectives of Narrative theory. Both theories intertwine well together as they create opportunities for those who are oppressed to speak about their narratives. Specifically, Africana womanism creates room for the Black family to be the center of human experiences, conveying a spirit that is more in tune to the realities of a racially unjust society (Ntiri, 2001). The specified population examined in this dissertation study hold social positions in various subjugated groups, from race, gender (for females), class and age. These lower-income Black adolescents' experiences in family therapy in RTF cannot be described without appropriate examination of these contextual variables, which can be thoroughly explained through the MCP. In sum, this study was based on the researcher's assumption that the experiences of lower-income Black adolescents' in family therapy in the RTF could not be fully understood without examining them through a socio-cultural perspective.

2.6 Conclusion

This chapter first attempted to set forth and critique the key literature on the mental health needs of the youth population of the US. Statistical data on the prevalence of specific mental disorders and the incidence of trauma among the youth population were discussed, followed by an examination of the existing racial, class and gender disparities in diagnoses. Overall, the demographic data and the data on disparities in diagnoses contribute to the conclusion that family therapy should be an integral part of therapies that are provided in RTFs. Subsequently, this chapter outlined the Narrative and Africana womanism theories, as well as the MCP. These three frameworks are used to

give descriptive context to the data elicited during the participant interviews. The precise methods of data collection and analysis are addressed in the following chapter.

CHAPTER 3: METHODS

3.1 Overview of Chapter

A qualitative transcendental phenomenological approach was utilized to answer the following central research question: *how do lower-income Black adolescents, 15 and 16-year-old, describe their experiences in family therapy in a residential treatment facility (RTF)?* An examination of the academic literature on residential treatment programs reveals several shortcomings in the subject of familial participation in therapy for adolescents in residential care settings. Previous studies have been methodologically limited because they were largely quantitative in nature. They were also temporally limited, in that they focused primarily on assessing outcomes *after* discharge from residential programs while neglecting occurrences *before* discharge. Indeed, there has been a lack of qualitative data collection and analysis that focuses on thoroughly highlighting the experiences of youth admitted to RTFs.

This chapter details the methodological aspects of this study. These aspects include: (1) conceptual justifications for the transcendental phenomenological approach; (2) rationale and assumptions underlying the research design; (3) researcher's role and reflections; (4) site and sample selection processes; (5) data collection, recording and management; (6) data analysis procedures; and (7) methods of trustworthiness. Each of these elements will be discussed in turn. It should be noted that the terms "participant" and "subject" are used interchangeably.

3.2 Research Design

3.2.1 Qualitative Research

The precise nature of what qualifies as qualitative research has been long debated in the academic literature (Newman & Benz, 1998). However, there is agreement that the qualitative analysis begins with a set of assumptions, a particular worldview, the possible use of a specific theoretical lens, and perhaps most importantly, the examination of research problems that seek to understand the meaning individuals or groups ascribe to a social phenomenon (Creswell, 2007). The qualitative approach is necessarily broad, encompassing virtually all social phenomena that need to be explored in detail (Bloomberg & Volpe, 2012; Creswell, 2007). A qualitative approach is uniquely suited to promoting a deep understanding of a social setting or activity, as viewed from the perspective of the research participants (Bloomberg & Volpe, 2012; Creswell, 2007; Richards & Morse, 2007). Furthermore, a qualitative inquiry facilitates a rigorous, in-depth analysis of issues (Bloomberg & Volpe, 2012; Flood, 2010; Patton, 2002). Denzin and Lincoln (1984) provide the following generic definition:

> Qualitative research is multi-method in focus, involving an interpretive, naturalist approach to its subject matter. This means that qualitative researchers study things in natural settings, attempting to make sense of, or interpret a phenomenon in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials- case study, personal experience, introspective, life story, interview, observational, historical, interactions, and visual texts that describe routine and problematic moments and meaning in individuals lives. (p. 2)

Unlike quantitative research, a qualitative approach emphases exploration, discovery and description of an identified issue. It involves paying attention to the interpretive nature of the inquiry while actively considering the political, social and cultural contexts of the researcher, the participant, and the readers of the study (Bloomberg & Volpe, 2012; Creswell, 2007). Qualitative researchers assume that there are social phenomena that cannot be readily quantified, but can be studied through alternative means. The aims of the quantitative and qualitative approaches need not be divergent or mutually exclusive. Indeed, they are often used together in mixed-method designs. However, proponents of the qualitative approach argue that it is not only possible, but critical, to determine in a rigorous way how groups and individuals interpret the non-quantifiable phenomena that impact their lives (Locke, Spirduso & Silverman, 2007). Successful qualitative research can be achieved through a variety of design types. The most prevalent types employed by researchers include: grounded theory, case studies, narrative, ethnography and phenomenology.

3.2.2 Phenomenology

This study adopted a phenomenological approach. The epistemology of phenomenology focuses on revealing meaning instead of arguing a singular position or developing an abstract theory (Flood, 2010). Rather, the phenomenological process is achieved through application of multiple theoretical perspectives, resulting in the application of the appropriate methodology. This process can be seen as both linear and sequential. The researcher begins his/her inquiry with a set of philosophical principles and assumptions from which a theoretical framework is created. The theoretical framework adopted by the researcher: (1) informs selection of the appropriate

methodology; (2) provides a context for the analytical process; and (3) builds a foundation for internal consistency of its logic and methodological criteria (Flood, 2010).

The two most prominent phenomenological approaches that a researcher may select are *transcendental* and *hermeneutic* (Richards & Morse, 2007; Wojnar & Swanson, 2007). The former approach is more descriptive while the latter approach is more interpretive (Flood, 2010; Richards & Morse, 2007; Wojnar & Swanson, 2007). When conceptualizing his/her research design, the researcher must determine which approach is most appropriate for the research inquiry, because, although both approaches do accentuate the importance of understanding human lived experiences, they do so with different emphases and goals (Flood, 2010; Wojnar & Swanson, 2007).

3.2.3 Transcendental Phenomenology

For this study, a transcendental phenomenological approach was employed because the researcher aimed to explore how lower-income Black adolescents *describe* their experiences in family therapy in a RTF. As noted above, transcendental phenomenology: (1) places a large emphasis on describing universal phenomena; (2) views a person as one representative of the world in which he/she lives; (3) holds the belief that consciousness is what human beings share; (4) assumes that self-reflection and a conscious "stripping" of previous knowledge by the researcher helps produce a pure expression of the phenomenon; and (5) assumes that adherence to established scientific protocols allows the researcher to describe universal essences (Koch, 1995; Wojnar & Swanson, 2007).

Transcendental phenomenology primarily focuses on obtaining detailed descriptions of the phenomena experienced by the participants involved, rather than a

hermeneutic interpretation of those descriptions (Creswell, 2007; Flood, 2010; Wojnar & Swanson, 2007). Successful application of the transcendental approach requires that the researcher consider only those descriptions imparted by the research subjects, while "transcending" personal biases. Thus, the data produced are truly "transcendental" in that "everything is perceived freshly, as if for the first time" (Moustakas, 1994, p. 34).

For this study, a transcendental phenomenological approach was optimal because the researcher was interested in gaining insight into the experiences of Black adolescents in family therapy in a RTF, as precisely described from their own perspectives. Moreover, the researcher sought to identify potential similarities in human experiences across subjects, uncover other identifiable patterns in the data, make conclusions from any discovered patterns, and, ultimately, find possible solutions to any problems indicated in the study's findings (Wojnar & Swanson, 2007). There is some practical methodological coincidence between the transcendental and hermeneutical approaches. However, although not entirely irrelevant, actual interpretation of the data is not the main concern in this study.

3.3 Rationale and Assumptions for Design

The rationale for this study is both academic and personal. As previously stated, a qualitative transcendental phenomenological approach was most appropriate because the principal goal of the study is to describe the lived experiences of lower-income Black adolescents in family therapy in a RTF. The researcher created a safe place for the subjects to provide rich, detailed descriptions of how they subjectively experienced family therapy in the RTF. A thorough examination of the relevant literature revealed that this question has been rarely studied, and the analytical approach proposed by the

researcher is novel. A transcendental phenomenological approach created room to empower the participants to share their stories, hear their own voices, and address the power imbalances that often exist between the researcher and the participants (Creswell, 2007).

In addition to making a meaningful contribution to the literature, the researcher's interest in conducting this study is personal and stems from her curiosity about the experiences of lower-income Black adolescents in a RTF. In her role as a RTF clinical therapist, the researcher observed inequalities in the experiences of the RTF youth, and noted the importance of factors such as race, gender, class and age in creating those inequalities. The following assumptions were derived from the researcher's clinical observations: (1) gender uniquely informed the experiences of RTF youth; (2) there was an increase in the female population in the RTF; (3) female residents presented with higher levels of internalized disorders, while males presented with higher levels of externalized symptoms; (4) the RTF population had an extensive history of relational trauma, which was most prevalent among the adolescent female population; and (5) family therapy was challenging due to several social factors. Given the researcher's observations, it was clear that the lower-income Black adolescent population needed to be studied more closely to obtain a deeper, understanding of their experiences in family therapy in the RTF.

3.4 Researcher's Role

Clark Moustakas (1995), a humanistic psychologist and phenomenologist, devoted his life's work to the study of therapeutic relationships. From his clinical experience, he was able to identify three primary conceptual stances that contribute to the

social dynamics of a relationship: "*Being-In*," "*Being-For*" and "*Being-With*" (Patton, 2002). "Being-In" involves immersing oneself in another's world and attempting to substitute another's perspective from one's own. "Being-For" involves one taking a stand in support of another, advocating for them and against others who might deny the value of their existence. Under the "Being-For" construct, another's perspective is not adopted as one's own; rather, one simply supports another's position. Finally, "Being-With" involves one's interaction with another as one's own person, with neither adoption of nor advocacy for another's position. In effect, "Being-With" conceives of a relationship as a joint enterprise in which meaningful contributions are made subjectively by both parties (Moustakas, 1995, p. 82-84).

For this study, the researcher assumed the posture of "Being-In." This meant that the researcher immersed herself in her subjects' worlds by listening deeply and attentively, so as to enter into their personal experiences (Patton, 2002). In doing so, she attempted to compile information in an unfiltered way, experiencing the subjects' narratives as if for the first time. The ultimate objective was to hear only what *is* while excluding her own biases. She interacted with subjects with the sole intention of understanding and accepting perceptions, not presenting her own personal views and reactions (Patton, 2002).

The researcher's assumption of the "Being-In" posture permitted an enhanced understanding of participants' experiences in family therapy in the RTF. In addition, the "Being-In" posture was consistent with the transcendental phenomenological methodological approach because it focused on the description of the experiences of the participants and far less on the researcher's interpretations of those experiences

(Creswell, 2007). Proper attention paid to the researcher/subject relationship is required for the successful completion of qualitative research. In collecting data for this study, the researcher set aside her own personal opinions and considered only those of the subjects. Thus, the "Being-In" posture was best suited for the study and was rigorously applied by the researcher.

3.4.1 The Bracketing Technique

To apply the "Being-In" stance successfully, the researcher sought neutrality through the technique of *bracketing*, also referred to as *epoché*, or *phenomenological reduction* (Gearing, 2004; Richards & Morse, 2007; Wojnar & Swanson, 2007). Bracketing has been described as: (a) separating the phenomenon from the world and inspecting it; (b) dissecting the phenomenon to unravel the structure, define it, and analyze it; and (c) suspending all preconceptions regarding the phenomenon and confronting the subject matter on its own terms, to ensure that the researcher holds in abeyance any preconceived ideas while he or she is listening to; and (d) interacting with and analyzing the stories of the participants (Giorgi, 1999; LeVasseur, 2003). Bracketing involved consciously and actively "stripping" away prior experiential knowledge and biases so as not to influence the descriptions of the phenomena under study (Tymieniecka, 2003). Bracketing required the researcher to disregard theories, research propositions and preconceived interpretations, so that authentic lived experiences can be heard (Gearing, 2004).

Stated otherwise, bracketing is the phenomenological reductive act of suspending judgment about the natural world so that the pure, objective essence of a thing is revealed (LeVassesur, 2003). Essential to bracketing and the "Being-In" stance is Husserl's (1931)

concept of *transcendental subjectivity* (*neutrality*), a concept he contends is key to understanding detachment from bias in the researcher/subject relationship. He defined neutrality as a state of consciousness in which the researcher successfully abandons his/her own lived reality to describe the phenomenon in its pure, universal sense (Husserl, 1931; LeVasseur, 2003). For Husserl, neutrality assumes that "prior knowledge could be suspended and set aside so that fresh impressions could be formed about the phenomena without interference of these interpretive influences" (LeVassesur, 2003, p. 409). In its simplest terms, neutrality implies that the researcher is not attempting to prove or disprove a particular perspective or to manipulate the data to arrive at predetermined conclusions (Patton, 2002). For this study, bracketing entailed ensuring that the researcher was fully conscious of her personal biases, and made all reasonable attempts from interfering with the researcher/participant relationship.

For this study, *ideal* (philosophical) bracketing was most appropriate, as it aligned well with the objectives of the transcendental phenomenological approach. Ideal bracketing involved two main steps: the suspension of presuppositions and focusing in on the essences of the phenomenon (Gearing, 2004). Ideal bracketing allowed the researcher to exclude all internal and external biases, set them aside, and hold in abeyance all of her "natural attitude" (Gearing, 2010). Internal suppositions are comprised of the subconscious biases of the researcher, such as personal knowledge, history, culture, experiences, and values, while external suppositions are centered on the phenomenon being investigated, such as its history, definition and other superordinate macro-environment factors (Gearing, 2010).

Ideal bracketing was most appropriate for the transcendental phenomenological approach applied in this study because it left the phenomenon to be studied in its bare form, so that the researcher may perceive it in its pure and natural state, free of external interpretation (Gearing, 2010). Ideal bracketing was crucial to data collection and analysis in this study because it allowed the researcher to control for her personal biases, which resulted from the following: (1) her role as a clinical therapist in the RTF, where the sample was selected, and (2) her identity as a woman of color, who has had experiences with economic and racial oppression. From these experiences and identities, the researcher admits to developing internal suppositions about the experiences of Black adolescents in family therapy in the RTF. Additionally, the researcher developed external suppositions about the environmental and socio-cultural factors that may influence the experiences of Black adolescents in family therapy in a RTF. These internal and external suppositions were identified and noted by recording them in written memoranda (Richards & Morse, 2007). They are highlighted in Chapter 4 of the Results.

3.4.2 Self of the Researcher Reflections

In the interest of full disclosure, it was important that the researcher elucidate her personal biases that may affect proper application of the "Being-In" stance. Potential professional biases stemmed from the researcher's previous employment as a clinical therapist in the RTF study site. They also stemmed from the researcher's racial/ethnic, gender, and religious identities and the way they manifested in her own interpersonal relationships. Although distinct, the two narratives are interconnected. The following section provides some background information and insights into the researcher's life

experiences that led to her interest in completing this dissertation study. They are presented below in first person.

Professional Narrative

In September of 2012, I began working as a therapist in a RTF located in Philadelphia. I felt privileged and excited to work in a RTF, as I was given the opportunity to make a difference in the lives of many underserved youth. The Couple and Family Therapy (CFT) Master's program at Drexel University focused heavily on issues relating to social justice, equality, and diversity. Hence, I assumed that my educational training and four-year post-master's clinical experience extensively taught me enough to address issues around social justice and equality. This further prepared me to provide competent clinical therapies to underserved populations. I was ecstatic about this opportunity.

My role as a clinical therapist entailed working collaboratively within an interdisciplinary team of psychiatrists, psychiatric nurses, clinical case managers, team leaders, residential counselors, and other third parties. My main job responsibilities included providing individual, family, and group therapies to my assigned caseload and measuring youth's clinical progress in the RTF. At times, I was also required to attend court hearings for high profile cases, in which a youth may be in danger of being removed from the facility. My role at court mainly consisted of advocating for the youth and being prepared to present any relevant clinical information on the youth's progress or lack thereof in treatment. Often I was asked to testify on the agency's behalf and justify whether the current facility was well-equipped to continue to provide mental health

services to the youth, despite my own professional recommendations against it. As a clinical therapist in the RTF, I was required to wear many professional hats.

Over the course of several months in this position, I encountered many eye-opening experiences with the adolescent youth and their families. These encounters sparked my interest in learning more about the experiences of the residential population in the RTF. Sadly, my experiences left me feeling discouraged, confused, hopeless, angry, frustrated, and at times, fearful for the youth. It always seemed that the clinical progress that was being made somehow deteriorated due to unforeseen and unexpected circumstances. These circumstances included, but were not limited to: (1) family stressors; (2) recent losses; (3) re-traumatization and re-victimization of youth (both within the facility and outside during home visits); (4) hopelessness of the youth themselves; and (5) the politics within the different SOC who were involved in the youth's care. I often went home questioning my competencies as a therapist, not recognizing that the struggles I was facing in working within the systems of rehabilitation (residential, legal justice system, and child protective services) were merely touching the surface of what these youth and families faced on a daily basis.

As I continued to reflect more on my emotions and experiences, it became clear to me that I was experiencing difficulties and challenges similar to those of the youth and the families I treated in therapy in the RTF. These included feelings of hopelessness, powerlessness, devaluation, loss of control, and the inability to make significant life decisions without impositions from other rehabilitation systems. I had the privilege of making autonomous decisions about my life, whereas the youth and families in the SOC did not necessarily hold that privilege. I was able to empathize with their experiences,

though I was not able to advocate for these youth and their families the way that I envisioned. There were many systemic roadblocks that I encountered that left me feeling discouraged and hopeless about the future of these youth. As I attempted to provide a safe, therapeutic setting for healing to take place for these youth and their families, other third parties utilized a more behaviorally-focused punitive approach.

As a clinical therapist, who thrives to work towards bringing social justice in this world, I did not agree with this behaviorally-focused punitive approach. Within a short time, I recognized that I needed to give voice to the lived experiences of these youth by allowing them to tell their stories in the therapy room in the RTF. I became even more curious about their experiences in individual, family, and group therapies. I knew exactly what I was experiencing in the therapy room with them, and had some ideas around what they might be experiencing. It was clear that something was broken within the rehabilitation SOC. Many of these youth had high rates of recidivism (both legally and residentially). Unfortunately, the current RTF was not their first residential placement and most likely would not be their last if changes did not take place on a systemic level. Most of these youth had prior involvement with mental health treatment, the legal justice system and CPS. Ultimately, these failed attempts in being repeatedly involved within the different SOC led to their confinement in a RTF. My curiosity in learning more about their experiences in therapy, specifically family therapy, encouraged me to conduct this research study.

As a trained family therapist, I believe in the power of healing through relational work. With this belief and the many challenges that I have faced in working with the families of youth in the RTF, I narrowed the focus of my study on examining the youth's

experiences in family therapy. My main interest in researching family therapy stemmed from the many difficulties that I have experienced in getting families to consistently participate in therapy. I had numerous conversations with the RTF youth regarding their experiences within their families, which enhanced my curiosity in studying the phenomenon of their experiences in family therapy. The majority of the youth addressed their difficulties in accepting the intense emotions, such as rejection, abandonment and neglect when their parent(s) and/or caregiver are not able to attend family therapy sessions. As a trained family therapist, I was able to sympathize with their experiences, along with understanding the socio-cultural factors that did not allow the parent(s) and/or care-giver(s) to engage consistently in family therapy. These socio-cultural factors included: (1) poverty/low SES; (2) single-parent homes; (3) increased responsibilities with other youth in the system; and (4) intergenerational patterns of mental health challenges, substance abuse and/or incarceration.

Personal Narrative

Given that the researcher is a vital instrument tool in a qualitative inquiry, it is important that the researcher explicitly locates him or herself socially, so as not to impose his or her personal biases, assumptions, and life experiences on the phenomenon being studied. As an educated, middle-class, single, 32-year-old, Pakistani, Muslim, heterosexual female, who was raised in a two-parent household, I have been able to find points of connection and disconnection with the lower-income Black adolescent population in the RTF. My interest in this research study stemmed from my own personal and clinical experiences in providing therapy in the RTF to the Black adolescents. I recognized very early on in my role as a clinical therapist that there were many

challenges that I was facing in providing family therapy to the specified population. There were many socio-cultural factors that impeded the process of family therapy. I encountered the most difficulties in making significant progress in family therapy, which extended the youth's discharge from the facility. The main concern for the youth was "going back into the same family environment," which could lead to further decomposition psychiatrically. Achieving the goals of family therapy were critical if the youth was being discharged back home. Clearly, this was a challenge and took a tremendous amount of time. This prolonged the youth's stay in the RTF, as the level of involvement from the families was minimal, if not limited.

Overall, most of the challenges that I experienced revolved around working within the different rehabilitations SOC. Other challenges important to note here stemmed from my own social locations, specifically the privileged positions I hold economically, academically, and familial (being raised in a two-parent household). These privileges were not afforded to the RTF population. The majority of the youth being admitted to the facility lived below poverty levels, in impoverished neighborhoods, lacked educational/academic opportunities, and experienced inconsistency in parental involvement, primarily biological fathers. I have also worked with many females whose mothers' were deceased, incarcerated, and/or suffered from their own mental health and/or substance abuse issues that hindered on their ability to provide for their child(ren). In these cases, the youth were in the care of grandparents, aunts or uncles (extended family members), or in the foster care system. Unfortunately, the intergenerational patterns of mental health, substance abuse, and trauma were prominent in the lives of the

youth that were admitted to the RTF. The privileges that I was afforded made the therapeutic process intricate, especially in building trust and rapport.

Despite these challenges, I was able to form trusting relationships with the youth through my experiences as a person of color, which allowed the Black adolescents to open up in therapy and make progress in their treatment goals. I hope that my social location as a person of color will transfer into the interview process. Also, as a female, I have been afforded the opportunity to develop a stronger relationship with the Black adolescent females. My interest in studying lower-income Black adolescents began from the many experiences I encountered with them and what they have described in the therapy room. These conversations in the therapy room involved discussions of their experiences of racism, sexism and classism at both micro and macro levels. I was able to empathize with their experiences of devaluation as I have also experienced oppression, discrimination, subjugation as a Pakistani Muslim female. As an immigrant, who moved to the US at the age of 7, I have overcome many hurdles to achieve my goals, which sadly have been intense and debilitating, at times, because of my cultural background.

I was exposed to many sexist beliefs as I came from a very traditional Pakistani Muslim family. My father was the head of the household and the decisions were seldom made by my mother. Despite having the privilege of growing up with two biological parents, who have been married for 37 years, my family life was very restrictive and abusive at times, mostly verbally and emotionally. There were isolated incidents of physical abuse towards my mother, me and my younger siblings. As the oldest sister of a sister and two brothers, I was given many responsibilities which were “culturally” appropriate as the oldest daughter in a Pakistani familial household. There were many

sacrifices that I was asked to make as a female. In reflecting back on those experiences, I lost a significant part of my life being the "parentified" child.

Additionally, I received consistent messages about having constraints as a female. I was not allowed to engage in many age appropriate activities, especially as an adolescent. I was repeatedly told that I could not do "this or that" because I was "a female", "a Muslim female" in particular. At that time, I had a very hard time understanding what my gender had to do with what I could or could not do, especially when the rules and regulations were reinforced in the context of my religion. Even more discouraging and frustrating was having younger brothers who were allotted more freedom with minimal rules and restrictions.

Over time, these sexist experiences led me to work harder to achieve the goals that my parents had set out for their children when they emigrated to the US. Their primary goal for us was *a higher education*. I worked exceptionally hard in school, as I knew that was one opportunity my parents would never turn down. I knew a higher education would empower me and give me a voice that will create opportunities to make a difference in this world. My own experiences of devaluation, as a Muslim female of color, spiked my interest in pursuing this research study with the lower-income Black adolescent population. I have observed many similarities in our lived experiences with racism, sexism, and classism, ultimately leading to experiences with devaluation. Because the dominant story of devaluation exists in many aspects of my life, as well as my subjects' lives, these experiences have given me the opportunity to empathize with the Black adolescent population in the RTF. My personal life experiences and the experiences of the lower-income Black adolescents and their families directed me to

conduct a qualitative research study, so that I could create space for their stories to be heard.

3.5 Site and Sample Selection Process

3.5.1 Site Selection

With regard to site selection, the researcher's previous employment in a RTF facilitated selection of the appropriate residential site. The researcher obtained permission from the Executive Director and Director of the RTF to collect data at the facility. The researcher obtained permission from the Institutional Review Board (IRB) at Drexel University before data collection commenced. The selected site met the following characteristics: (1) a secure, lock-down 24-hour facility; (2) provision of residential and clinical services (individual, family and group therapies); (3) provision of pharmacological therapy (psychiatric medication management); (4) average census for the past few years has remained between 85-100 youth (fewest had been 50 and most had been 110); (5) services are rendered to both male and female youth; (6) age group variation between 10-17 years old, with youngest being 9 years of age and oldest being 21 years of age, with an average age of 15 years of age; and (7) an average length of stay (LOS) of roughly 9-12 months, with shortest LOS of 3 months and longest LOS of 36 months.

As of April 2016, the male: female ratio at the site was 43:52, with a total of 95 youth residing in the facility. It is important to note here that the above data was provided by the Clinical Coordinator of the RTF program, who has been managing and recording the demographics data for the past several years. Specific data on race, class and other categories had not been officially monitored in the monthly reports that are submitted to

funding sources. The researcher collected some of that data from the demographic survey.

3.5.2 Participant Selection

This study applied the concepts of *purposeful* and *criterion* sampling. Purposeful sampling requires that the researcher select subjects for the study in a manner that purposefully informs an understanding of the research problem (Creswell, 2007). Qualitative inquiry typically focuses in-depth on small samples, even single cases, selected purposefully (Patton, 2002). Creswell (2007) recommends criterion sampling for phenomenological studies. Criterion sampling works well for phenomenological studies as it allows for subject selection based on specific criteria, such as individuals who have experienced a similar phenomenon (Creswell, 2007). Individuals who have not experienced the phenomenon under study do not meet the specified criteria and are, thus, excluded. Criterion sampling is useful because it ensures the elimination of any future quality assurance concerns.

Participants for the study were identified through the Clinical Coordinator of the RTF program, who oversees all intakes and admissions to the facility. The Clinical Coordinator was provided information on the inclusion and exclusion criteria so that he was able to accurately identify qualified participants. He sought assistance from the residential clinical therapists to identify eligible participants. Once the requisite number of potential participants was identified, the Clinical Coordinator briefed each one on their obligations under the terms of the study to obtain verbal informed consent. If interest in participation was demonstrated, the Clinical Coordinator scheduled a time for the initial interview to take place in the RTF with the researcher. Parental consent was obtained for

all participants. Written consent was also obtained during the first interview. Payment in the amount of $25 was provided to each participant and was distributed upon completion of their second interview. It should be noted that the site selected for data collection was also the researcher's former employer. Thus, to eliminate interview bias, an exclusion criteria to participate in the study was no prior ties with the researcher as a former RTF client.

3.5.3 Sample Size

In utilizing the criterion sampling technique in this transcendental phenomenological research study, the Clinical Coordinator assisted the researcher in identifying 15 subjects, 11 males and 4 females. It is well understood that the key to criterion sampling is selecting those cases from which one can learn the most (Krathwohl & Smith, 2005). With regard to phenomenological qualitative approaches, the sample sizes tend to be relatively small, ranging from 1 to 325 cases (Creswell, 2007). Sample size parameters in qualitative studies are, in part, a product on the particularistic goals of the researcher. Several questions are key to determining the appropriate sample size: (1) What is the overall purpose of the inquiry? (2) How generalizable should the study's conclusions be? (3) How much credibility does the researcher want his/her findings to have? and (4) What are the practical limitations (temporal, material, and financial) that may restrict sampling? (Patton, 2007).

After careful consideration of these questions, a sample size of 20 was deemed optimal; however only 15 participants were interviewed. Creswell (2007) recommends a small, manageable sample size of three to 10 subjects for a phenomenological research design. However, to increase generalizability of results and to maximize the amount and

type of data collected, a sample size of 15 was appropriate. The more data collected, the firmer the foundation that the study can lay for future research. In the event that a participant was unable to complete the research study, a replacement subject was immediately selected based on the original inclusion and exclusion criteria. All 15 participants who initially agreed to participate in the study completed it in its entirety. There were a few participants who were identified to participate in the study but could not due to extraneous factors, such as researcher's inability to obtain consent from Department of Human Services (DHS) and clinical rationale providing evidence of emotional instability.

3.5.4 Inclusion and Exclusion Criteria

For the study, there were four primary inclusion criteria: (1) subjects had to be 15 or 16 years of age, (2) subjects had to self-identify as Black and African American; (3) subjects had to be in residence at the RTF for at least 6 months; and (4) subjects had to have participated in a minimum of 6 family therapy sessions. These criteria fit well with current demographic data regarding RTF populations. According to the American Association of Children's Residential Center (AACRC), residential care programs are designed for seriously disturbed youth, ages 17 and younger (AACRC, 1999). Approximately 75% of the youth population in residential care is between the ages of 13 and 17 (Warner & Pottick, 2003). Additionally, in examining the statistics of mental health, the onset of major mental illness occurs as early as 7 to 11 years of age and roughly half of all lifetime mental health disorder start by mid-teens (Kessler et al., 2007; Stagman & Cooper, 2010). The average age of adolescents being admitted to residential care is 15 and 16 years of age, which justifies the need to examine the adolescent

population more closely to gain a comprehensive understanding of their experiences in family therapy in a RTF (Warner & Pottick, 2003).

Racially, the participants must have self-identified as Black and African American. A study by Warner & Pottick (2003) revealed that 65% of the youth population in residential care is white, which is consistent with the percentage of the US population that self-identifies as white. The authors also noted that their findings were surprising given the high prevalence rate of Black and Hispanic youth involved in the social services and juvenile justice systems, many of whom ultimately end up in RTFs (Warner & Pottick, 2003). Given the changing nature of the services being provided to Black adolescent RTF residents, along with the researcher's interest in studying the Black RTF population, the criterion that all study participants self-identify as Black and African American was integral.

Finally, the participants must have resided in the facility for a minimum of 6 months, allowing ample time for them to participate in at least 6 family therapy sessions. Family therapy sessions generally occur bi-weekly in the RTF. For a session to be considered a "family therapy session" a resident and at least his/her caregiver must have been present at the session. There was no upper limit to the number of family members who could participate in therapy. As the average residential stay for youth is between 9-12 months, a minimum of a 6-month stay was appropriate for this study. The selected residential duration allowed for more detailed data collection because it provided sufficient time for subjects to formulate opinions about the RTF residential culture, specifically family therapy.

Exclusion criteria for the proposed research study were few and included: self-identifying as transgender or transsexual, and having a diagnosis of mental retardation, autism disorders, or any other cognitive/learning disabilities. The treating psychiatrist's clinical diagnosis helped eliminate those potential participants who met the exclusion criteria. Finally, participants who had any prior ties with the researcher in her role as a clinical therapist in the RTF were excluded from the study.

3.5.5 Potential Risks and Benefits

In conducting the study, several precautionary steps were taken to ensure the safety of the participants, especially their emotional safety, given the sensitive nature of the subject matter. Full disclosure was provided to the study participants. Both the benefits and risks were clearly articulated on the consent forms and the researcher reviewed all provisions of the form thoroughly and explicitly with each participant and legal guardian. Both parties were informed that their (the youth's) participation was completely voluntary and that consent could be freely withdrawn at any time without consequence. They were also informed of the $25 payment that would be paid upon completion of the two interviews. Both gave written consent to have their interviews audio-recorded. Recording is important for the preservation of interview data, and to maintain accuracy in data analysis. Legal guardians signed release forms so that the researcher had access to the youth's clinical information, in addition to any other information that could be pertinent to the study.

The researcher highlighted the benefits of the study to the participants and their legal guardians. The primary benefit of participation in a study was that it would ultimately assist academics in understanding the lower-income Black adolescent RTF

population. Data collected could also help mental health professionals and therapists better understand the needs of the specified population as it concerns family therapy. There were also potential individual benefits, most importantly having their voices heard and their opinions taken seriously, creating a sense of personal empowerment.

The researcher anticipated some emotional risks for the proposed study. Because the topic was sensitive, the interview questions could evoke strong emotional reactions such as anger, resentment and depression. As the population being studied was young and vulnerable, it was imperative that an emergency crisis plan be set in place. In the event that participants displayed any signs of emotional reactivity/dysregulation, the interview process would be immediately halted to allow the participants to remove themselves from the interview, compose themselves and process their emotions. The Clinical Coordinator was available on site to assist the researcher in managing any crises that may arise. All participants met with the Clinical Coordinator after interview completion to process their (emotional) responses.

Participants also had access to a therapeutic sensory room to exercise a variety of self-regulating coping skills. The sensory room is a designated area on site which is utilized to promote self-organization (regulation) and positive change. The purpose of the sensory room is to: (1) create a safe space; (2) facilitate therapeutic alliance; (3) provide opportunity for engagement in prevention and crisis de-escalation; and (4) promote self-care, self-nurturance and recovery. To accomplish these tasks, there are several therapeutic activities available in the sensory room that stimulate individual senses, such as medicine balls, sand trays, play dough, ultra-violet lights and aromatherapy interventions. Sensory rooms, in the RTF, are individualized to age-appropriate activities.

Furthermore, participants had access to their clinical and residential teams 24 hours a day. The assigned on-call clinical therapist was available to respond to crises that may have resulted from a youth's participation in the study. The on-call clinical therapist would initiate any referral to the crisis response center (CRC) that might occur after business hours. In such an event, the following steps would be taken: (1) the Clinical Coordinator would be contacted (he was available onsite); (2) the on-call clinical therapist would be contacted and apprised of the incident; (3) the on-call therapist would reach out to the Clinical Operational Director, who would then contact the psychiatrist; (4) the on-call psychiatrist would be informed of the incident and make the final decision as to clinical and/or medication interventions; (5) the residential Program Director would be contacted to arrange transport through the transportation department at the facility if the subject needed to visit the CRC; and (6) the on-call clinical therapist would provide any documentation needed for the CRC to determine the proper course of therapeutic intervention. Once appropriate clinical treatment had taken place, the subject would return to the RTF. Luckily, the research study did not encounter any crisis situations during the interview process. One identified female participant, who met all inclusion criteria, was excluded from the study due to emotional liability, which may have posed a potential risk. This decision was made by her RTF clinical therapist, Clinical Coordinator and the researcher, so as to avoid any further safety concerns.

3.6 Data Collection, Recording, and Management

Data was collected primarily through interviews conducted at the study site. Fieldwork entails direct and personal contact with study participants in their own environment to gain a personal understanding of their daily lives (Creswell, 2007; Locke

et al., 2007; Patton, 2002). For a qualitative researcher, approaching fieldwork without the constraints of predetermined categories contributes to the depth, openness and detail of the experiences of the participants (Patton, 2002). The researcher is the main instrument in qualitative research and his/her skills are very critical (Richards & Morse, 2007; Patton, 2002). The researcher's skills ensure the quality of the data, the interpretations of the results and the proposal of the theory (Patton, 2002; Richards & Morse, 2007).

A fieldwork research design frequently involves collection of data from different sources, sometimes by different methods, within a natural setting. Data most commonly takes the form of recorded words, which may include field notes, interview transcripts, and diaries and/or written observations (Creswell, 2007; Locke et al., 2007). Use of a variety of data collection methods allows for *triangulation* of data, a cross-checking of information to ensure accuracy (Locke et al., 2007). Triangulation, not only resolves discrepancies in data collection, it also allows for follow-up when authenticity of sources needs to be established (Locke et al., 2007).

There are several triangulation techniques. This study utilized *data triangulation* and *investigator triangulation*. Data triangulation entails the use of many data sources in a study, while investigator triangulation entails the use of several different researchers and evaluators who can bring different perspectives and challenge the primary researcher's propositions (Patton, 2002). Data triangulation was achieved by conducting face-to-face interviews, reviewing relevant documentation, reviewing demographic surveys and listening to audio-recordings.

Investigator triangulation was achieved by having regular meetings and conference calls with the researcher's consultant and chair. The researcher remained mindful of her biases throughout the data collection and analysis process. The researcher also followed up with the study participants to correct for errors in data collection and analysis. Finally, the researcher engaged in the process of journaling and memoing to explicitly highlight her biases and assumptions.

The researcher collected data from participants using in-depth, face-to-face, semi-structured interviews in a secured, private setting in the study site. Open-ended interview questions were used to allow participants to tell their stories freely. Open-ended interview questions enabled the researcher to capture participants' perspectives without restriction by rigid questionnaire categories (Patton, 2002). Unlike closed-ended questions, more flexible questions allowed the researcher to capture participants' narratives in their entirety, instead of within a strict set of guidelines or rules that predetermine the relevancy of the data. Thus, constraints on what participants could or could not discuss during the interviews were minimal. Interview questions were selected based on their consistency with the researcher's goals and to serve as a basis for additional questions that might contribute to a more detailed narrative.

Audio tapes were used to record the interviews, so that accuracy of the data collected could be triangulated and accessed at a later time. Follow-up interviews were conducted once the first round of data analysis was completed. Given that the average LOS in the RTF is 9-12 months, the researcher did not foresee completion of follow-up interviews as problematic, unless the participant refused to participate, was discharged

from the facility against medical advice (AMA), or was removed from the RTF through the legal system.

The researcher completed the entire study in roughly 6 months. Data was transcribed by Fingers4Hire Transcription Services on a weekly basis. This allowed for the quick turnaround of transcribed initial interviews, so that the researcher could complete the second interviews quickly. Only 2 participants were interviewed for their second interview in the community, as they were discharged from the facility shortly after the initial interview. As discharge was already anticipated for these two participants, the researcher had obtained prior consent to reach out to them afterwards to complete the second interviews. They were interviewed in the privacy of their homes and awarded the $25 at that time.

Overall, data was collected and recorded through completion of the initial demographic survey, semi-structured interviews and access to the admission packet, which provided extensive documentation of the participant's mental health history, family dynamics, trauma and loss history, child protective service and/or legal involvement. This information allowed for cross-checking of data provided on the demographic survey and in the interview. Interviews were audio-taped, transcribed and analyzed manually by the researcher.

Along with collecting and recording data, it was important for the researcher to manage the data appropriately. In this study, data management began with bracketing prior to data collection. The interviews were conducted, examined, and coded throughout the interview process, beginning after the completion of the first five initial interviews. The researcher constructed codes and themes to organize and collate data collected. The

researcher kept a reflective journal, along with memoranda, to clarify the data, and made sure to set aside her own biases regarding the findings. The data was organized, transcribed (by transcription service), and analyzed manually by the researcher herself, with the assistance of her research assistant.

Preservation of the confidentiality of data was prioritized and ensured by assigning a pseudonym name to each subject. Other relevant information was secured through the process of redaction. The researcher kept documentation in a secure-locked cabinet. The computer and storage device were secured with "sign-on" passwords. Data were backed-up and stored in a separate location from the original. For example, data were both saved on the desktop and flash drive, in case either became lost, damaged or otherwise unable to be recovered, so that the data were rendered irretrievable from either location. The flash drive was secured in a locked cabinet to which only the researcher had access. To further ensure confidentiality and privacy of the data, the researcher utilized a university approved encrypted USB flash-drive retrieved from the Information Resource and Technology (IRT) Department at Drexel University. Additionally, the audio tape recordings and transcripts were stored separately from demographic surveys (information) and consent forms, which indicated participant identity. The only individuals that had access to the demographic surveys (information) and consent forms were the researcher, research assistant and dissertation chair. This process of securing data was explained to all participants prior to obtaining their consent.

3.7 Data Analysis Procedures

In transcendental phenomenology, data analysis is outlined in four overlapping steps*: (1) bracketing, (2) analyzing, (3) intuiting, and (4) describing* (Wojnar & Swanson,

2007). As discussed previously, bracketing is a researcher's attempt to achieve the state of transcendental subjectivity (neutrality and openness to the reality of others) by setting aside prior understanding or preconceptions about the phenomenon being researched (Gearing, 2007; Richards & Morse, 2007; Wojnar & Swanson, 2007). In part, phenomenological researchers accomplish neutrality by memorializing their assumptions and expectations in writing (Richards & Morse, 2007).

During the analysis phase, the researcher of the study bracketed by: (1) using field notes as a reflective dairy to write down her observations, assumptions and confusions; (2) seeking critiques from methodological experts or others who might have personal or professional experience with the topic; and (3) being cautious about the role her personal and professional biases may play when making sense of the data (Richards & Morse, 2007; Wojnar & Swanson, 2007). The researcher actively engaged in reflective journaling and memoing to set aside her own suppositions while collecting and analyzing data (Bloomberg & Volpe, 2012). Memoing involved recording and writing notes about certain occurrences or experiences that seemed of vital interest, and that may: (1) inform the manner in which data are coded; (2) affect how the data is interpreted and findings are made; (3) influence how conclusions are arrived at; and (4) impact the recommendations for policy changes or for future research (Bloomberg & Volpe, 2012). More importantly, memos ignite an ongoing internal dialogue within the researcher during the entire research process that is cognitively and analytically challenged (Bloomberg & Volpe, 2012). Along with journaling and memoing, case consultations with the research consultant took place regularly. The dissertation chair and methodologist were also consulted on the research project.

In addition to the four transcendental phenomenological steps previously mentioned, Wojnar and Swanson (2007) recommend utilizing Colaizzi's (1978) method in data analysis. The following seven steps are included in Colaizzi's method: (1) reading and re-reading the participants' descriptions of the phenomenon; (2) extracting significant statements and/or quotes that concern to the phenomenon; (3) formulating meanings for those significant statements and/or quotes; (4) categorizing the formulated meanings into clusters of themes that are common to all participants; (5) integrating the findings into exhaustive descriptions of the phenomenon; (6) validating the findings by re-interviewing some participants; and (7) incorporating any changes suggested by participants into the final descriptions of the phenomenon (p. 176). Giorgi (2000) describes a similar process, referring to the various data-derived themes as "meaning units." (Bloomberg & Volpe, 2012; Giorgo, 2000). It is imperative that Colaizzi's steps be applied with precision to ensure accurate, in-depth descriptions of the phenomena under study.

First, reading and re-reading the descriptions allows the researcher to gain a sense of the data in its entirety, and as experienced by the participants themselves. In this study, the researcher reviewed interview recordings several times to bracket and write down any thoughts and feelings she may have had during the interviews. Next, the formulation process builds upon reading and re-reading in that it highlights contextual meanings and assigns meaning to the interview data so that it may be sorted or coded into categories, themes or clusters of themes. In this study, the original interview transcripts were used to assist in validation and confirmation of consistency between the researcher's conclusions and the participants' original narratives (Bloomberg & Volpe, 2012; Creswell, 2007; Wojnar & Swanson, 2007).

Coding is simply a process of classifying and categorizing data by type or some other attribute. The process of coding requires noting what data are of interest or significance, identifying different segments of the data, and labeling and organizing those data (Bloomberg & Volpe, 2012; Richards & Morse, 2007). Saldana (2009), elaborates further on the subject of coding:

> A code in qualitative inquiry is most often a word or short phrase that symbolically assigns a summative, essence-capturing, and/or evocative attribute for a portion of language-based or visual data…. Just as a title represents and captures a book or film or poem's primary content and essence, so does a code represent and capture a datum's primary content and essence. (p. 3)

Codes are, in fact, a type of shorthand: "the names or identifiers that you attach to chunks or segments of data that you consider relevant to your study, hence the researcher can use any system that works well for him or her" (Bloomberg & Volpe, 2012, p. 142). During coding, data *make* the categories by alerting the researcher to certain patterns (Richards & Morse, 2007). Coding is also a way of fracturing the data, so that a linkage can be formed from the data to the ideas, and then from the idea to all of the data relevant to that idea (Richards & Morse, 2007). In doing so, coding reduces the data and creates groupings and sub-groupings of information (Bloomberg & Volpe, 2012).

For this study, the researcher coded the interview transcripts, closely examining single words, phrases, sentences, quotes and whole paragraphs to develop themes. A theme is defined as "a *phrase* or *sentence* that identifies what a unit of data is *about* and/or what is *means*" (Saldana, 2009, p.139). It is a common thread and/or recurring pattern that runs through the data (Bloomberg & Volpe, 2010; Creswell, 2007; Richards

& Morse, 2007). As described by Moustakas (1994), this step is also called *horizontalization*, a process by which the researcher sifts through the data and highlights important statements, sentences or quotes that provide an understanding of how the participants experience the studied phenomenon (Creswell, 2007). To make emergent themes in the data readily cognizable, *repetition* has been described as the most common technique. If a concept is repeated enough times throughout an interview or across interviews, it can be reasonably labeled a theme (Bloomberg & Volpe, 2012). Important themes then serve as the basis of descriptive statements, authored by the researcher, which describe participants' experiences (Creswell, 2007; Flood, 2010).

In the analysis phase, the themes that were created through the coding process are verified by the participants for accuracy in interpretation and fit with the participants' lived experiences. Once data validation is completed, the researcher incorporates any interpretive changes suggested by the participants into the researcher's final descriptions. (Wojnar & Swanson, 2007). Regarding data analysis, the researcher for this study followed all of Colaizzi's recommended steps, from reading and re-reading the participants' descriptions of their experiences in family therapy in RTF, to coding those experiences into specific themes, and, ultimately, to returning to the participants to verify accuracy and truthfulness in the researcher's classification of the data.

The last two steps of data analysis in a transcendental phenomenological study are intuiting and describing. In simplest terms, intuiting has to do with the innate sense of what it is like to "live in the participants' skin" (Wojnar & Swanson, 2007). As accounts of experiences are generated, the researcher's intuition is stimulated by additional data through active, attentive listening, which permits critical reflection about the similarities

that may exist across the participants' stories. Intuiting requires a conscious effort to understand "what it must be like" to live the experiences of the subjects (Wojnar & Swanson, 2007). Since the researcher of this study has had the opportunity to work with the RTF population being studied, she understood and empathized with participants' lived experiences. Although the researcher did bracket her personal and professional biases to the extent necessary to construct a robust research design, it must be noted that her experiences did assist in intuiting during the data analysis process.

In the describing phase of the study, the researcher presents a theoretical model to conceptualize the core structures of the studied phenomenon. This is done by explicitly identifying a composite, rich (thick) description of the "essence" of the phenomenon (Creswell, 2007; Wojnar & Volpe, 2012). Specifically, the researcher develops a *textural description* and a *structural description*. A textural description represents *what* the participants actually experienced, while a structural description represents *how* the participants experienced the phenomenon, in terms of the condition, situation or context (Bloomberg & Volpe, 2012; Creswell, 2007). If an individual who has experienced the phenomenon is able to identify their own experiences in the researcher's proposed description, then the researcher's description can be verified as accurate (Wojnar & Swanson, 2012).

To ensure accuracy in descriptions, the researcher of this study returned to the participants' post- initial interview to seek feedback through the process of member-checking. As a result, adjustments were made to the descriptions as needed. The $25 payment was used to incentivize participation in follow-up interviews. Prior to consent, it was explained to all participants that the $25 payment would be made once the entire data

collection process was complete, including a two-part interview. As per the consent agreement, if a subject was discharged from the facility prior to a second interview, the researcher made every reasonable attempt to contact members of the subject's family. Chapter 4 will provide step-by-step details on the data analysis process pertaining to the results of this dissertation study.

3.8 Methods of Trustworthiness

Transcendental phenomenological research focuses on trustworthiness rather than on validity (the degree to which something measures what it purports to measure) and reliability (the consistency with which it measures it over time) (Bloomberg & Volpe, 2012; Creswell, 2007). The central focus is on how well the researcher has provided evidence that her/his descriptions and analysis represent the reality of the experiences of the subjects studied (Bloomberg & Volpe, 2012). To evaluate trustworthiness, Guba and Lincoln (1998) developed four interrelated concepts: (1) *credibility*, (2) *transferability*, (3) *dependability*, and (4) *confirmability* (Bloomberg & Volpe, 2012; Creswell, 2007; Patton, 2012; Richards & Morse, 2007).

"Credibility" parallels the criterion of validity in some respects, as it refers to whether the participants' perceptions coincide with the researcher's description of them, or whether the description accurately represents what the participants think, feel and do (Bloomberg & Volpe, 2012). To achieve credibility in findings, researchers must clarify and monitor their biases from the beginning to the end of the study, by recording reflective field notes and/or keeping a journal (Bloomberg & Volpe, 2012; Creswell, 2007; Richards and Morse, 2007). Credibility can be increased through prolonged stay in the field, persistent observations, triangulation, the search for negative cases, discussions

or debriefings with peers and verification of results from study participants (Bradley, 1993).

"Transferability" parallels the criterion of generalizability, often used in quantitative research. Transferability focuses on whether and how the methodology of the study in question allows other researchers to identify substantially similar phenomena in similar contexts (Bloomberg & Volpe, 2012). In qualitative research, transferability is assessed by the "thickness" of the description, or the degree to which the description promotes a shared or vicarious experience (Bloomberg & Volpe, 2012). In short, transferability is achieved when the reader feels as if they are *living* the experiences described (Bloomberg & Volpe, 2012). Of obvious importance is the amount of detailed information the researcher is able to provide in his/her descriptions of the phenomena (Bloomberg & Volpe, 2012; Bradley, 1993). It is the researcher's responsibility to provide the requisite amount and type of data, through which rich, ample description can be conveyed (Bradley, 1993).

Third, "dependability" parallels the criterion of reliability and refers to whether one can track the processes and procedures used to collect and analyze the data (Bloomberg & Volpe, 2012). It refers to the degree of coherence and consistency of the data analysis process, accomplished through an "internal audit" (Bradley, 1993). The internal audit should result in an "audit trail," a detailed and convincing chronology of how the data was collected, coded and interpreted (Bloomberg & Volpe, 2012). For dependability and inter-rater reliability, the researcher's colleagues may be asked to independently code several interviews. Ideally, the researcher's coding should be free

from undue bias and be reproducible by the researcher's peers (Bloomberg & Volpe, 2012).

The final criterion of "confirmability" refers to the extent to which the characteristics of the data, as described by the researcher, can be confirmed by others who read the research results (Bradley, 1993). Confirmability parallels the criterion of objectivity in quantitative research and implies that the findings are the result of the data, rather than a result of researcher subjectivity (Bloomberg & Volpe, 2012). To achieve confirmability, the researcher of this study employed various analytical devices, such as bracketing, journaling and memoing, as well as recording field notes and transcripts. These precautions provided assurances that future researchers would be able to assess the viability of the study's findings, conclusions and recommendations (Bloomberg & Volpe, 2012).

3.9 Conclusion

This study made a meaningful contribution to the literature on CFT by filling the gaps in method and perspective. It used a rigorous qualitative, in-depth approach that provides researchers a window into understanding the subjective experiences of lower-income Black adolescents in family therapy in a RTF. In addition to contributing to the depth and breadth of the research, this study entices future researchers to investigate the plight of the lower-income Black adolescent residential population.

CHAPTER 4: RESULTS

4.1 Overview of Chapter

The current chapter discusses the results of this transcendental phenomenological dissertation study. It outlines step-by-step details on the qualitative process that was utilized by the researcher to analyze data that was obtained through the demographic surveys and semi-structured interviews. Methods of trustworthiness are also addressed in this chapter. Overall, the findings of the study highlighted 6 major themes that emerged from the data. These themes included: *(1) views on receiving family therapy in the residential treatment facility (RTF); (2) therapeutic alliance and relationship with RTF therapist; (3) developmental and cognitive shifts in self; (4) treatment goals in family therapy in the RTF; (5) views on racial inequalities and injustices; and (6) experiences with trauma and loss.* Each of the 6 main themes encompassed subthemes, 24 total, which are clearly outlined in Table 4.9.

Quotes from the participants are included in this chapter to illustrate the frequent occurrences of the 6 main themes and 24 subthemes. Additionally, interview data are presented to evidence the frequency with which participants situated their respective RTF experiences within the social contexts of their race, gender, age and class. Confidentiality was protected by using pseudonyms for each participant. The following tables are utilized to organize the data retrieved from the demographic survey and interviews:

- Table 4.1 (p.152) provides census data on recent demographics of the RTF population upon the study's completion;
- Table 4.2 (p. 153) presents demographic information on the 15 male and female participants;

- Table 4.3 (p.155) highlights statistics on 11 different reasons for admission to the RTF;
- Table 4.4 (p.158) presents data on participants' involvement in other systems of care, specifically the juvenile justice system and child protective services (CPS);
- Table 4.5 (p.160) provides information on the history of mental health treatment for each individual participant in 6 treatment settings;
- Table 4.6 (p. 161) shows averages of the 6 mental health treatment settings for study participants;
- Table 4.7 (p.163) organizes DSM-5 diagnostic disorders that show prevalence (in ascending order) for the study participants;
- Table 4.8 (p.164) provides demographic information on the 8 RTF therapists who conducted family therapy with the 15 participants;
- Table 4.9 (p.186) highlights 6 major themes and 24 subthemes that were formulated from the data analysis.
- Table 4.10 (p.189) provides examples of internal and external suppositions of the researcher that were noted in memos during the data collection and analysis process.

4.2 Demographics of RTF Population

As of April 2016, the total census of the RTF was 95 residents, with 43 males (45%) and 52 females (55%). Data on the past two years show that in 2015 the RTF average census was 95.5, and in 2014, the average census was 91.3. The current average age of the youth is 15 years old, with the youngest youth being a 12-year-old male. The oldest youths in the RTF were 18 years old, 1 male and 1 female. Racially, out of the 95 youth residing in the RTF, 67 (71%) identified as Black/African-American, 24 (25%) identified as White/Caucasian, and four (4%) identified as Hispanic/Puerto-Rican. These data were collected during the admission process when intakes are completed by the Clinical Coordinator. Data on socio-economic status were not collected from the youth or families in the RTF during the intake process; thus, the Clinical Coordinator was not able to provide that information.

Table 4.1

Census Data of RTF Population

Census	Gender	Race	Age
95	Males- 43 Females - 52	Black/African American- 67 White/Caucasian- 24 Hispanic/Puerto-Rican- 4	Average- 15 Youngest- 12 Oldest- 18

4.3 Demographic Survey Results

4.3.1 Demographic Information

Fifteen (n-15) adolescents, who self-identified as Black and African-American, participated in this research study. Their ages were 15 or 16 years old, with a *mean* age of 15.5 years old. Eight of the participants were 15 years old and 7 of the participants were 16 years old. Four females (27%) and 11 males (73%) participated in the study. Fourteen of the participants (93%) identified as heterosexual and 1 female participant identified as

bisexual (7%). All 11 male participants (100%) identified as heterosexual. In reference to religious affiliation, 8 participants (53%) identified as Christian and 7 participants (47%) identified as Muslim. Out of the 8 participants who identified as Christian, 1 participant identified as Catholic. In highlighting statistics on gender and religious identification, 6 males (75%) identified as Christian and 2 females (25%) identified as Christian. Five males (71%) identified as Muslim and 2 females (29%) identified as Muslim.

Data on socio-economic class were obtained from the participants through self-reports. Each participant was asked to identify their class status as upper, middle or lower. Twelve participants (80%) self-identified as middle-class; 2 participants (13%) self-identified as upper-class; and 1 participant (7%) self-identified as lower-class. All 4 female participants (100%) self-identified as middle-class. Eight of the 11 male participants (73%) self-identified as middle-class. Two male participants (18%) self-identified as upper-class and 1 male participant (9%) self-identified as lower-class. These findings are notable as the results of the participants' self-identification as middle-class is incongruent with their actual lived experiences as lower-class.

Table 4.2

Demographic Information of Study Participants

Demographic Category	# of Participants	% of Total Participants
Gender	• Males- 11 • Females- 4	• Males- 73% • Females- 27%
Age	• 15 years old- 8 • 16 years old- 7	• 15 years old- 53% • 16 years old- 47%
Religion	• Christian- 8 • Muslim- 7	• Christian- 53% • Muslim- 47%
Sexual Orientation	• Heterosexual- 14 • Bisexual- 1	• Heterosexual- 93% • Bisexual- 7%
Socio-Economic Status	• Upper- 2 • Middle- 12 • Lower- 1	• Upper- 13% • Middle- 80% • Lower- 7%

4.3.2 Reasons for Admission

Data were collected on reasons for admission for each study participant. Table 4.3 presents statistics on 11 different reasons for admission to the current RTF. All 15 participants (100%) reported being admitted to the RTF for reasons pertaining to aggressive and/or assaultive behaviors towards others. This also included homicidal behaviors such as homicidal ideations, threats, and gestures. One male participant specifically reported engagement in homicidal behavior (attempted murder). Six participants (40%), 3 males and 3 females, were admitted for suicidal behaviors, which included suicidal attempts, suicidal ideations and/or self-injurious behaviors. Five participants (33%), 3 males and 2 females, engaged in some form of destructive behavior that led to admission to the RTF. Examples of destructive behaviors included throwing a desk at a teacher and punching holes in walls.

Five participants (33%), 3 males and 2 females, were admitted to the RTF for running away behaviors, either from home or other RTFs. Four participants (27%), all males, reported being transferred to the current RTF due to failure to adjust (FTA) in another facility. Reasons for FTA transfer included the following: increased aggressive/assaultive behaviors towards staff and/or peers; numerous absences without official leave (AWOL); incidents from previous facility; minimal therapeutic progress in the program; refusal to engage in therapeutic treatment; adjustment issues; and/or inability for the program to meet youth's treatment needs. Four male participants (27%) were admitted to the RTF for weapon related incidents, such as threats with a deadly weapon (knife and scissors) and bringing a weapon to school.

Three participants (20%), 2 males and 1 female, were admitted for reasons relating to substance (drug or alcohol) use and/or possession. Three male participants (20%) were admitted to the RTF for robbery and/or burglary. Two male participants (13%) reported history of fire-setting behaviors that led to their RTF placement. Two participants (13%), 1 male and 1 female, reported issues with truancy in school, such as skipping school and/or refusing to attend, leading to increased absences. Lastly, 1 female participant (6.7%) reported cruelty to animal (kicking a cat).

Table 4.3

Reasons for Admission to the RTF

Reason for Admission	# of Participants	% of Total Participants
Aggression/Assault (Towards Others)	**Total- 15** • Males- 11 • Females- 4	**Total- 100%** • Males- 73% • Females- 27%
Suicidal Behaviors	**Total- 6** • Males- 3 • Females- 3	**Total- 40%** • Males- 20% • Females- 20%
Destruction/Damage to Property	**Total- 5** • Males- 3 • Females-2	**Total- 33%** • Males- 20% • Females-13%
Running Away Behaviors	**Total- 5** • Males- 3 • Females- 2	**Total- 33%** • Males- 20% • Females- 13%
Failure to Adjust (FTA)	**Total- 4** • Males- 4 • Females- 0	**Total- 27%** • Males- 27% • Females- 0
Weapon Related Incidents	**Total- 4** • Males- 4 • Females- 0	**Total- 27%** • Males- 27% • Females- 0
Substance Related Incidents	**Total- 3** • Males- 2 • Females- 1	**Total- 20%** • Males- 13% • Females- 7%
Robbery/Burglary	**Total- 3** • Males- 3 • Females- 0	**Total- 20%** • Males- 20% • Females- 0

Fire-Setting	**Total- 2** • Males- 2 • Females- 0	**Total- 13%** • Males- 13% • Females- 0
Truancy	**Total- 2** • Males- 1 • Females- 1	**Total- 13%** • Males- 6.5% • Females- 6.5%
Animal Cruelty	**Total- 1** • Males- 0 • Females- 1	**Total- 6.7%** • Males- 0 • Females- 6.7%

4.3.3 Length of Stay in RTF

Each participant in the study met the criterion of 6 months for their length of stay (LOS) in the RTF. At time of initial interviews, 12 participants (80%) had recently met their six-month mark in the RTF to be eligible for the study. Two participants (13%) resided in the RTF for 11 months and 1 participant (7%) resided in the RTF for 7 months at time of initial interview. The *mean* LOS for both males and females was 6.7 months. The *mean* LOS for the 11 male participants was 6.6 months and for 4 females was 7.1 months.

4.3.4 Family Therapy Sessions

Participants must have completed 6 family therapy sessions, either over the phone or face-to-face with a family member, caregiver and/or legal guardian. The 15 study participants met this criterion and had a minimum of 6 family therapy sessions over the course of their treatment in the RTF. The *mean* of completed family therapy sessions for study participants was 9.5, with the highest number of family therapy sessions as 20 and lowest number of family therapy sessions as 6. The *mean* average for the 4 female participants was 12 family therapy sessions, with highest number of sessions as 20 and lowest number of sessions as 7. The *mean* for the 11 male participants in the study was

8.6 family therapy sessions, with highest number of family therapy sessions as 15 and the lowest number of family therapy sessions as 6.

Family members who participated in family therapy sessions included: biological parents (mother, father or both), and grandparents (maternal or paternal) who had legal guardianship of the youth. Six participants (40%) engaged in family therapy sessions with their biological mothers. Two participants (13%) engaged in family therapy sessions with their biological fathers. Three participants (20%) engaged in family therapy sessions with their biological parents, either both attending in person or one parent participating over the phone. All 3 of these participants reported that their parents were separated. Lastly, 4 participants (27%) engaged in family therapy sessions with their biological grandparent(s) and other family member(s), to include an aunt and older sister.

4.3.5 Involvement in Other Systems of Care

Data were obtained regarding participants' involvement in other systems of care, specifically the legal juvenile justice system (probation) and child protective services (CPS) through the Department of Human Services (DHS). This information was gathered through questions on the demographic survey, in addition to cross checking self-reports with information available in the participants' psychiatric evaluations. Table 4.4 presents data on the 15 participants' involvement in the legal and CPS systems of care.

Overall, 10 participants (67%), 9 males and 1 female, had legal involvement. Five participants (33%), 2 males and 3 females, reported no legal involvement. Eight participants (53%), 6 males and 2 females, had CPS involvement. Seven participants (47

%), 5 males and 2 females, had no CPS involvement. Six participants (40%), 5 males and 1 female, had both legal and CPS involvement. Only 3 participants (20%), 1 male and 2 females, reported no involvement in these two systems of care. Demographical data also examined the differences in gender and participant involvement in legal and CPS systems of care. Nine out of the 11 male participants (82%) had legal involvement. Two out of the 4 female participants (50%) had legal involvement. Six of the 11 male participants (55%) had CPS involvement. Two out of 4 female participants (50%) had CPS involvement. Five male participants (45%) and 1 female participant (25%) had both legal and CPS involvement. One male participant (9%) and 2 female participants (50%) had no involvement in either the legal or CPS systems of care.

Table 4.4

Systems of Care Involvement

Systems of Care	Involvement (% of Total)	No Involvement (% of Total)
Legal	**Total- 10 (67%)** • Males- 9 (60%) • Females- 1 (7%)	**Total- 5 (33%)** • Males- 2 (13%) • Females- 3 (20%)
CPS	**Total- 8 (53%)** • Males- 6 (40%) • Females- 2 (13%)	**Total- 7 (47%)** • Males- 5 (34%) • Females- 2 (13%)
Legal & CPS	**Total- 6 (40%)** • Males- 5 (33%) • Females- 1 (7%)	**Total-3 (20%)** • Males- 1 (7%) • Females- 2 (13%)

4.3.6 History of Mental Health Services

Data were gathered on the history of mental health treatment for each participant in 6 different treatment settings. These included: (1) outpatient treatment; (2) intensive outpatient treatment (IOP); (3) community based services (CBS); (4) acute partial hospitalization programs (APHP); (5) inpatient psychiatric hospitalizations; and (6) residential treatment facilities (RTF). Each treatment setting listed here is recognized as a

modality on the different levels of care (LOC) spectrum, which ranges from least to most restrictive. Outpatient treatment is the least restrictive (lowest) level of care and inpatient psychiatric treatment is the most restrictive (highest) level of care.

Age of First Contact

The *mean* age of first contact with mental health treatment for all 15 participants was 8.9 years old. The average age for the 11 male participants was 9 years old and for 4 female participants was 8.8 years old. The *modes* for the participants' age of first contact were 8 years old, 2 males and 1 female, and 10 years old with 3 male participants. The youngest age of contact to mental health treatment was 5 years old, reported by 2 participants, 1 male and 1 female. The oldest age of contact to mental health treatment was 13 years old, reported by 2 participants, 1 male and 1 female.

History of Mental Health Treatment

Table 4.5 organizes data on each participant individually, as obtained through self-reports while completing the demographic survey. The information was verified through data available on each participant's psychiatric evaluations. The numbers noted on the table indicate the number of times treatment was received in each level of care. The value of "0" was assigned to data that was not available to the researcher. It is safe to assume that each participant has received lower levels of care before being admitted to the RTF, as mental health treatment usually follows a progressive pattern, with initial efforts to utilize services in the community (Aaron et al., 2010; American Academy of Child and Adolescent Psychiatry, 2010). As noted in the literature review, youth are placed in higher levels of care, such as RTFs and inpatient psychiatric hospitals, when other community treatment options have failed and the youth presents with high levels of

dangerous behaviors (Aaron et al., 2010; Stagman & Cooper, 2010; Zelechoski et al., 2013).

Table 4.5

Participant History of Mental Health Treatment

Participant Pseudonym	Age of 1st Contact	Outpatient	IOP	CBS	PHP	RTF	Inpatient
Jaleel	8	1	0	1	0	5	1
Jahmir	7	2	1	1	1	1	2
Jalecia	8	4	1	1	0	1	2
Khalil	5	1	0	1	2	2	4
Sarena	13	0	0	1	4	0	3
Yasir	9	2	0	1	1	3	1
Andre	12	2	0	0	0	0	1
Aaron	10	2	0	1	1	0	1
Darnell	10	2	0	1	2	2	3
Deshawn	10	2	0	1	1	1	3
Nashay	9	0	0	1	0	1	5
Ciara	5	4	0	1	1	1	4
Nadeer	8	0	0	1	0	1	0
Jaquan	7	0	0	0	0	4	0
Elijah	13	1	0	0	0	1	2

Furthermore, Table 4.6 expands on data presented in Table 4.5, providing statistics on the averages of the participants' previous history of mental health treatment in different settings. Thirteen participants (87%), 9 males and 4 females, had a history of inpatient psychiatric hospitalizations. Twelve participants (80%), 9 males and 3 females, had a history of previous RTF admissions to other facilities. Three participants (20%), 1

female and 2 males, reported no history of previous RTF treatment, with current placement as their first admission. Twelve participants (80%), 8 males and 4 females, had a history of receiving treatment through community based service (CBS) programs. These included two different programs: Family-Based Services (FBS) and Behavioral Health Rehabilitation Services (BHRS). Both of these services are available to younger children, starting with BHRS and transitioning to FBS, if minimal to no progress is shown. This statistic shows consistency with the average age of first contact (8.9 years old). Eleven participants (73%), 9 males and 2 females, had a history of receiving outpatient treatment to include individual therapy, family therapy and medication management. Eight participants (53%), 6 males and 2 females, had a history of treatment in an acute partial hospitalization program (APHP). Two participants (13%), 1 male and 1 female, had a history of treatment in an intensive outpatient program (IOP).

Table 4.6

Participant History of Mental Health Treatment in Different Settings

Treatment Settings	# of Participants	% of Total Participants
Inpatient Hospitalizations	**Total- 13** • Males- 9 • Females- 4	**Total- 87%** • Males- 60% • Females- 27%
Residential Treatment Facilities (RTF)	**Total- 12** • Males- 9 • Females- 3	**Total- 80%** • Males- 60% • Females- 20%
Community Based Services (CBS)	**Total- 12** • Males- 8 • Females- 4	**Total- 80%** • Males- 53% • Females- 27%
Outpatient Treatment	**Total- 11** • Males- 9 • Females- 2	**Total- 73%** • Males- 60% • Females- 13%
Acute Partial Hospitalization Programs (APHP)	**Total- 8** • Males- 6 • Females- 2	**Total- 53%** • Males- 40% • Females- 13%

Intensive Outpatient Programs (IOP)	**Total- 2** • Males- 1 • Females- 1	**Total- 13%** • Males- 6.5% • Females- 6.5%

4.3.7 Treating Diagnoses

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was utilized by the treating Psychiatrists in the RTF to classify, diagnose and treat each participant. The following DSM-5 psychiatric disorders showed prevalence (from most to least occurring) in the participants: conduct disorder; post-traumatic stress disorder (PTSD); attention-deficit hyperactivity disorder (ADHD); disruptive mood deregulation disorder (DMDD); oppositional defiant disorder (ODD); intermittent explosive disorder (IED); cannabis use disorder; depressive disorder; major depressive disorder (MDD); mood disorder; general anxiety disorder (GAD); reactive attachment disorder (RAD); obsessive compulsive disorder (OCD); and binge-eating disorder.

Eleven participants (73%), 9 males and 2 females, were diagnosed with conduct disorder. Seven participants (47%), 6 males and 1 female were diagnosed with PTSD. Seven participants (47%), 6 males and 1 female, were diagnosed with ADHD. Six participants (40%), 3 males and 3 females, were diagnosed with DMDD. Four participants (27%), 3 males and 1 female, were diagnosed with ODD. Four participants (27%), 3 males and 1 female, were diagnosed with IED. Three male participants (20%) were diagnosed with cannabis use disorder. Two participants (13%), 1 male and 1 female, were diagnosed with depressive disorder. The following disorders were prevalent in 1 study participant (6.7%): MDD (male); mood disorder (female); GAD (male); RAD (male); OCD (male); and binge-eating disorder (female). Table 4.7 also provides the averages.

Table 4.7

DSM-5 Diagnoses

DSM-5 Disorders	# of Participants	% of Total Participants
Conduct Disorder	**Total- 11** • Males- 9 • Females- 2	**Total- 73%** • Males- 60% • Females- 13%
Post-Traumatic Stress Disorder (PTSD)	**Total- 7** • Males- 6 • Females- 1	**Total- 47%** • Males- 40% • Females- 7%
Attention-Deficit Hyperactivity Disorder (ADHD)	**Total- 7** • Males- 6 • Females- 1	**Total- 47%** • Males- 40% • Females- 7%
Disruptive Mood Deregulation Disorder (DMDD)	**Total- 6** • Males- 3 • Females- 3	**Total- 40%** • Males- 20% • Females- 20%
Oppositional Defiant Disorder (ODD)	**Total- 4** • Males- 3 • Females- 1	**Total- 27%** • Males- 20% • Females- 7%
Intermittent Explosive Disorder (IED)	**Total- 4** • Males- 3 • Females- 1	**Total- 27%** • Males- 20% • Females- 7%
Cannabis Use Disorder	**Total- 3** • Males- 3 • Females- 0	**Total- 20%** • Males- 20% • Females- 0
Depressive Disorder	**Total- 2** • Males- 1 • Females- 1	**Total- 13%** • Males- 6.5% • Females- 6.5%
Major Depressive Disorder (MDD)	**Total- 1** • Males- 1 • Females- 0	**Total- 6.7%** • Males- 6.7% • Females- 0
Mood Disorder	**Total- 1** • Males- 0 • Females- 1	**Total- 6.7%** • Males- 0 • Females- 6.7%
General Anxiety Disorder (GAD)	**Total- 1** • Males- 1 • Females- 0	**Total- 6.7%** • Males- 6.7% • Females- 0
Reactive Attachment Disorder (RAD)	**Total- 1** • Males- 1 • Females- 0	**Total- 6.7%** • Males- 6.7% • Females- 0
Obsessive Compulsive Disorder (OCD)	**Total- 1** • Males- 1 • Females- 0	**Total- 6.7%** • Males- 6.7% • Females- 0
Binge-Eating Disorder	**Total- 1** • Males- 0 • Females- 1	**Total- 6.7%** • Males- 0 • Females- 6.7%

Each participant showed co-morbidity with one or more psychiatric disorders

4.4 Demographics of RTF Therapists

The researcher of the study collected demographical information on the 8 therapists who provided family therapy to the 15 participants. It was important to obtain this information as the participants discussed specific socio-cultural contexts that influenced their experiences in family therapy in the RTF. The race and gender of the therapist were most frequently discussed by the participants. Class was vaguely mentioned, and when it was discussed, the participants reported that class had no influence on the therapeutic relationship with their RTF therapist and/or the therapy process. Demographic information in other areas (i.e. SES, license, and degree), presented in Table 4.8 below, was also collected from the therapists to gain a clear picture of the therapist population in the RTF.

Table 4.8

Demographic Information of RTF Therapists

Demographic Category	# of Therapists	% of Total Therapists
Gender	Females-7 Males-1	Females- 87.5% Males- 12.5%
Race	White/Caucasian- 3 Black/African American- 2 Hispanic- 1 Other- 1 Not Reported- 1	White/Caucasian- 37.5%Black/African American- 25% Hispanic- 12.5% Other- 12.5% Not Reported- 12.5%%
Socio-Economic Status	Middle- 6 Other- 1 Not Reported- 1	Middle- 75% Other- 12.5% Not Reported- 12.5%
License	No- 6 Yes- 2	No- 75% Yes- 25%

Degree	MSW- 3 MHSC- 1 MFT- 1 Creative Arts Therapy- 1 Clinical/Community Counseling- 1 Clinical Counseling (MFT)- 1	MSW- 37.5% MHSC- 12.5% MFT- 12.5% Creative Arts Therapy- 12.5% Clinical/Community Counseling- 12.5% Clinical Counseling (MFT)- 12.5%

As noted, there were 8 RTF therapists who provided clinical services to the study participants. The majority of the therapists were females with 7 total (87.5%) and 1 male therapist (12.5%). Racially, there were variations observed in the demographics, with highest number being 3 with White therapists (37.5%), followed by 2 therapists who identified as Black and/or African-American (25%). One therapist (12.5%) identified as Hispanic, 1 identified (12.5%) as other and 1 therapist (12.5%) did not provide data on race. Therapists were asked about their SES, in which 6 therapists identified as middle-class (75%), 1 therapist (12.5%) identified as other and 1 therapist (12.5%) did not identify class status. Only 2 therapists held licenses (25%), one with a family therapy license (LMFT) and one with a social work license (LSW). Six therapists (75%) reported that they did not obtain their licenses yet.

In reference to the therapists' graduate degrees, all therapists (100%) had a master degree in some form of counseling and/or therapy professions. This is minimally required to provide clinical services to youth and families in RTFs and other treatment settings. Three therapists (37.5%) received a master in social work (MSW); 1 therapist (12.5%) received a master in human services- clinical degree (MHS-C); 1 therapist (12.5%) received a master in family therapy (MFT); 1 therapist (12.5%) received a master degree in creative arts therapy (CAT); 1 therapist (12.5%) received a master degree in clinical

and community counseling; and 1 therapist (12.5%) received a master in clinical counseling with a concentration in marriage and family therapy (MFT).

4.5 Transcendental Phenomenological: Data Analysis Process

The primary aim of this transcendental phenomenological dissertation study was to describe the experiences of lower-income Black adolescents in family therapy in a RTF. As formerly noted, the researcher gathered data by completing a demographic survey (Appendix A) and semi-structured interviews with 15 participants. The interview lasted between 30-45 minutes. During the interview, the researcher utilized sampling questions (Appendix B) to answer the main research question. Data analysis was conducted on the semi-structured interviews by employing the following four steps: (*1) bracketing; (2) analyzing; (3) intuiting; and (4) describing* (Wojnar & Swanson, 2007).

To ensure that the formation of accurate, detailed, in-depth (thick) descriptions of the phenomenon were depicted, the researcher implemented Colaizzi's (1978) seven steps of analysis (noted in Chapter 3 of Methods). The following 6 main themes emerged from the data analysis: *(1) views on receiving family therapy in the residential treatment facility (RTF); (2) therapeutic alliance and relationship with RTF therapist; (3) developmental and cognitive shifts in self; (4) treatment goals in family therapy in the RTF; (5) views on racial inequalities and injustices; and (6) experiences with trauma and loss.* Table 4.9 provides information on the 24 subthemes that evolved from the "data-making" process (Richards & Morse, 2007). A brief overview of each of the 6 themes and 24 subthemes is presented below, followed by an in-depth discussion of the data analysis process.

4.5.1 Emerging Themes and Subthemes of Study

Theme 1: Views on Receiving Family Therapy in the RTF

The first dominant theme that emerged from the data analysis described the participants' *views on receiving family therapy in the RTF*. The following 3 subthemes were noted within theme one: *(1) part of treatment in the RTF; (2) discharge from RTF; and (3) positive experiences in family therapy in the RTF*. All 15 study participants discussed their understanding of receiving family therapy in the RTF as part of the "treatment process that was required of them," because it would assist in "getting them discharged from the facility." They described family therapy sessions as a means to "going home on passes," "me going home," "getting discharged from here," "help me get out of this system" and "helping me get back to my family." Deshawn noted family therapy as "part of the rules here" and happens "probably to get us back home." He also stated that "it's helping me get home passes" and "can get me home to see my friends and hang out."

Despite the participants' expression of family therapy being "required" and/or "mandated" in the RTF, most participants' (12 out of 15) viewed family therapy positively. This was evident through the following participant quotes regarding their experiences in family therapy: "being helpful," "having empathy," "being more open-minded," "gaining trust," "being honest," "opening up and communicating," "dealing with family issues and problems," "getting closer to family," "expressing my feelings and emotions," "learning to walk away," "making better decisions" and "listening to each other."

Theme 2: Therapeutic Alliance & Relationship with RTF Therapist

The second emerging theme that was described by the participants was *therapeutic alliance and relationship with their RTF therapist,* with the following 3 subthemes noted*: (1) previous negative experiences in family therapy; (2) positive attributes describing relationship with RTF therapist; and (3) validation and acknowledgement of experiences by RTF therapist.* The participants compared their family therapy experiences in the RTF with other treatment settings. They reflected on their previous experiences in family therapy as being unpleasant. The participants felt family therapy was unhelpful in the past due to their experiences with "feeling unheard," "feeling like the therapist was not listening," "the therapist did not understand them" and "the therapist not really caring."

Elijah directly described his previous experiences with feeling dismissed in therapy:

> I feel that I was not heard…either because I don't open up and I don't speak my mind, or because they just don't understand me. I grew up with a number of people that don't understand me. I stopped speaking my mind. But I just started speaking my mind again.

Elijah further highlighted how he experienced "feeling misunderstood and unheard in therapy at other places," as well. On the contrary, all of the study participants (15 out of 15), described their relationship with their therapist as "good", "very good," or "great," despite their views on receiving family therapy as a requirement in the RTF. Most participants described the therapeutic relationship as a "process" that took time to "get used to." Their experiences in family therapy in the RTF helped them form an "open,

trusting, honest" relationship with their therapist, which allowed them to "open up and talk about their issues and feelings in sessions." Jalecia expressed her experiences in family therapy as "frustrating" in the beginning as she felt her therapist did not "understand" her. She agreed that her relationship with her therapist evolved over time:

> I think my relationship with my therapist is good now. Before I felt like she didn't want to talk to me or my mom. I think she just didn't know what to say because she not us. Sometimes I got frustrated because I feel like she's not getting it or she's taking one person's side and not other. But I think she is starting to understand how to talk with us better and understand who we are and what we need to communicate. She has gotten to know us and got a better understanding of us. She now knows what to say, how to come across, who to let talk, what we need to talk about, or how is this and what's going on with it.

Jalecia's shift in her relationship with her therapist was the result of her therapist creating a space for her to express herself openly. The therapist was able to "listen" to Jalecia, and "actually taking it in and applying it." Here, Jalecia was clearly describing her experiences with feeling "heard" and validated, as her RTF therapist was able to acknowledge and value her perspectives. The therapist aligned with Jalecia by giving her a voice, taking feedback, and making the advised necessary changes. These positive experiences in family therapy in the RTF assisted in the formation of a trusting therapeutic relationship between Jalecia and her therapist.

Additionally, other participants used words and phrases, such as "understanding," "being helpful," "giving advice," "listening," "being supportive," "having someone to talk to" and "helping to go home," to describe their therapists' behaviors that contributed

to building a relationship with them. Andre identified his therapist as someone who was on his "side." He stated "when I say something she'll say- you're right and your mom should let you do certain stuff as a teenager." He felt validated and understood by his RTF therapist in family therapy sessions.

Distinctively, Ciara was able to describe how her therapist has helped her identify and use different coping skills to address her problematic behaviors, such as banging on things, getting loud and kicking staff. She described the guidance and support she received from her therapist in finding different ways, through writing, to express herself in family therapy in the RTF:

> I get along with my therapist. I have learned to control my anger by counting to three, calming down, and then starting over again. Taking deep breaths. I don't like to talk too much. But I can sit there and write to my therapist about how I'm feeling or what happened to me in the past. She can say it out loud in my family sessions and I just do that. Then my mom will talk to me about it and she saying, why didn't you just say it when you was at home.

Yasir also gained support from his RTF therapist in being able to express himself to his mother. He stated "if I have a problem with my mom, she (therapist) will have a heart to heart conversation with my mom to let my feelings out" so that we can "let each other know what we're going through and how we feel about each other so we can fix the problem." He maintained "that's been going well lately." Similarly, Sarena reported her RTF therapist gives her a voice in her family therapy sessions:

> Sometimes she just tells my grandma what she sees that she's doing is wrong and she's my therapist, so I might tell her more things… like I might tell her things

> that I don't tell my grandma, so my therapist tells her or helps me tell her in a respectful way, if I can't.

Overall, the participants' positive experiences in family therapy in the RTF largely have been influenced by their alliance and relationship with their RTF therapists, which developed over time through guidance, support, validation, trust and honesty. Elliot described his positive experiences (below) with the therapists in the RTF, allowing him to develop trust in the therapy process, which was lacking previously. He noted:

> For one, the therapists here, they're earning our trust before anything. They actually took the time to know us and what we are working with. They tried to understand it in our eyes, like point to point. They want us to succeed and they're not just sayin' it. The paycheck, they don't care about and my therapist, I believe that from her. She actually has earned my trust and not a lot of people earn that trust from me because I have trust issues and all that other stuff.

Lastly, it is important to highlight the experiences of the 3 participants, all males, who did not necessarily find family therapy in the RTF to be appealing. Nadeer and Deshawn stated "I just gotta fake it 'til I make it," implying that they were "just doing it so you can get out the place where you don't want to be." Despite having these views on family therapy as "not being helpful," both were able to identify how family therapy could overall be potentially useful to individuals in building healthy familial relationships.

Likewise, Khalil questioned the purpose of family therapy in the RTF as "he finds himself to be dragged down by his family" and that "it's an emotional disturbance." Despite having these challenges experiences in family therapy with his grandmother, Khalil was able to express that family therapy has been "helping him improve on

strengthening his mental capacity and emotional intelligence," which helps him deal with his family. Family therapy has helped him "grow up, learn new things and ideas and make better choices."

Theme 3: Developmental & Cognitive Shifts in Self

The third theme that emerged from the data analysis was *developmental and cognitive shifts in self* that the participants experienced in family therapy in the RTF. Five subthemes evolved from the research data obtained from the study: *(1) changes in views on family therapy; (2) willingness and desire to change own behaviors; (3) self-motivation towards achieving future goals;(4) influence of parental involvement and engagement on own behaviors; and (5) restrictions in mobility as a result of RTF admission.*

Being admitted to the RTF changed their perceptions on utilizing family therapy to their advantage. As previously noted, all participants described their views on receiving family therapy in the RTF as part of the treatment process. Engagement in family therapy ultimately led to achieving their goals of going home and being discharged from the facility. This was a source of motivation for them to participate more openly in sessions and use therapy to make positive changes for themselves. Moreover, in describing their experiences, the participants highlighted how they have "changed" and "matured" because of their life experiences, mainly from being "stuck" in the RTF. Ciara described her experience in different SOC that led to her utilizing therapy as a tool to make changes:

> When I kept going in and out of the hospital, and then finally got locked up and then was looking around the youth in here…like it's not a place that I want to be

> and I don't want no other kid to be in this facility. This is when I started talking to my therapist. It was eye opening for me. Now I can talk about the incident that happened to me, to my brother, uncle and step-dad. I can talk to them about anything now. I use therapy instead of getting mad. I'll read a book. I'll write…do crochet and that's it.

Yasir also described the changes that he has seen in himself because of his admission to the RTF:

> For me, it (therapy) helped me cooperate and helped me with my anger and my emotions and how to control myself and not snap. When I'm feeling down now, I talk to people because if I snap out, they're not going to know how I'm feeling. A person can't help you if you don't want to be helped, so I had to learn the hard way. Then I improved and that's when I started cooperating more because I wanted help and I don't want to be like that for the rest of my life with people saying that person he's not there all the way. I wanted the help so I can be better in life.

He further goes on to say, "it's just like I'm a young man and I'm growing up, so I've got to make better decisions and better choices in life that will help me be better for me and my family."

Elijah reported changes in himself in how he approaches family therapy. When questioned regarding his own contributions in utilizing therapy, he stated: "me caring to do therapy…uh- hmmmm and actually wanting to do it now. Not just wanting to get it over with, actually being consistent in doing it. I want to go home now." He highlighted how his experiences in being away from home and losing people (relationships) has

forced him to "grow-up." Specifically, he stated: "the people that I lost, the things I've realized from being away from home for so long, made me just grow up basically. Since I've been out of the house and away from my home, I've had a little bit more freedom and more time to realize what I'm doing is wrong and stuff like that." Likewise, Andre described his experiences in the RTF as:

> A life learned lesson but it's not good. It's been a life learning experience for me because to figure out the behaviors I was doing wasn't right and if I did it later on in life, I wouldn't be able to get the help I needed because people wouldn't really care because I'm an adult…they wouldn't care but as a child, they want to help you.

Here Andre provides some clarity on how his admission to the RTF allowed him to reflect on his experiences as an adolescent and not an adult. It has been an eye-opening event in his life, which contributed to the developmental and cognitive changes he has experienced in the RTF.

Jahmir described that his views on therapy have shifted over time, as he originally disliked therapy and felt "weird" doing it. However, now he feels family therapy is "normal" and an important part of developing positive family relationships. In some ways, the developmental and cognitive shifts he described below have put things in perspective for him. Early family interventions to address family functioning were apparent in his descriptions of the significance of family therapy in the lives of youth. He stated:

> I mean I feel normal doing therapy now. It's human and not an un-normal thing. It's a lot of people out there that do therapy, especially family therapy, so I don't

> have a problem with it. It don't feel weird at all. I know I didn't really want to do it growing up. I thought I had better things to do than that. I thought people would think that I was weird because I had to go to family therapy. I was only thinking about myself and how I would look if I went to family therapy. I wasn't thinking about the outcome of family therapy. Like I probably wouldn't be here right now. I probably would be home because I probably would've got what I needed done. I probably would've had a better functioning family.

Theme 4: Treatment Goals in Family Therapy in the RTF

The fourth theme that emerged from the qualitative analysis of the semi-structured interviews was *treatment goals in family therapy in the RTF*. Similarly, 6 subthemes were developed through the data analysis. These included: *(1) "it's my behaviors that put me in here…;" (2) "I want to go home…;" (3) effective communication and appropriate self-expression; (4) emotional regulation and management; (5) developing healthy family relationships; and (6) using empathy to understand others' experiences.*

Aaron felt "family therapy happens because they want to see if you and your family have a good connection or try to fix what you have lost or something." He explained the meaning of "what you have lost" as "like your relationship with your parents; like how you feel towards them; how you act towards them; the things that you did to your parents and things like that." Khalil also stated that family therapy is supposed to "improve your family and the issues you have with your family…sort them out." Similarly, Jahmir described his understanding of family therapy, as it related to his experiences in sessions with his father:

> My understanding of family therapy is trying to work on communicational skills, getting along with family and trusting each other. So I guess, since I got here my family therapy sessions have been going good. I like them. Since I started them, I've gotten a little closer to my family. I've opened up more to my dad and I never really use to do that. They really do help with my problems inside of the family because instead of pushing my family to the side and not talking to them about my issues that I had with them, family therapy kind of helps me to open up more, so we can start to get those issues out of the way.

Jahmir's experiences in family therapy thoroughly highlight the experiences of the majority of the study participants. Many participants described family therapy as a process that assisted in achieving specific treatment goals. Effective communication and appropriate self-expression showed prevalence in each participant's views on receiving family therapy. For example, Nashay stated "family therapy is about helping you with your family situations. If you're not having a good relationship with your mom, like me, we have to talk about it and how you would like to change it and what you gonna do to change it." Jalecia also expressed similar views on receiving family therapy in the RTF. She reported family therapy as:

> Basically to me, it's just helping me and my family communicate better. How we get things out if we can't say them ourselves, having someone else say them for us and help us communicate better…. me and my family worked on our anger with each other and how we come across and say things to each other more. Just basically the way we talk, the way we put our words and how we just answer and understand each other…we both have feelings.

Sarena also described her experiences in family therapy as:

> Bringing you and your family together so ya'll can- I guess if you don't express yourself and don't talk to your family, you won't know each other's differences or know more about each other… I don't know. To help ya'll get through the treatment.

She further goes on to say "we talk about me making better decisions and my grandmother listening to me…that's really like…talking about the situations and things I want to resolve with my family and stuff." Aside from learning ways to express one's self in positive ways, the descriptions, noted above, shed light on the participants' learning new skills in being empathetic. The participants reported family therapy has allowed them to develop empathy towards others (their family members) and understand their perspectives. Sarena discussed how she has been able to understand the views of her grandmother, which has helped modify how she relates to her. This ultimately has brought changes in her behaviors towards her grandmother, as she has "learned to let go of anger, resentment, and grudges." This has allowed her to "forget what happened in the past and forgive."

Furthermore, Nadeer's descriptions allude to managing his behaviors and making the necessary changes needed to be successful in life. He highlights the significance of empathy to make these changes: "we talk about overcoming stress and putting yourself in their shoes (with) just a lot of empathy (so that) when someone say something smart to you, the only thing you gotta say is- you got it, my fault, my bad for stepping on your sneaker." In making similar behavioral changes, Khalil reported:

> Therapy here is more open. Other places it's more you have to do this and it's not really like you can express how you feel, they just tell you. I mean you can express how you feel but you gotta find your own coping skills and stuff like that. Here it's more given to you. They give you coping skills, like MP3s and stuff like that.

Nadeer's descriptions above further reiterate the importance of emotional regulation and management, which was discussed by all 15 participants. Nadeer was able to highlight his experiences with his therapist as being:

> Helpful by at least helping to talk about my feelings…, sitting me down and talking about my feelings because I didn't really have nobody to do that for me in my life to talk about things and get shit off your chest.

Other participants' own words and expressions, such as "my anger and the way I react to certain things;" "like my coping skills when I'm angry;" "teach you other things to learn how to control your anger and other emotions;" "talking to someone so I don't take it out in a negative direction;" and "keeping me calm."

Several participants provided in-depth descriptions on the subtheme of the influence of parental involvement in family therapy in the RTF. All 15 participants were required to participate in a minimum of 6 family therapy sessions in the RTF, with a parent, caregiver and/or legal guardian. For the purpose of this theme (study), the word "parental" is operationally defined as "an adult who has been the primary person engaging in family therapy with the participants and has legal guardianship, regardless of their parental and/or biological relationship." As noted earlier, family members who engaged in family therapy sessions with the participants were biological parent(s),

paternal or maternal grandparent(s), aunt and older sister. The participants were able to identify these parental influences as rewarding, encouraging, and overall motivational in pushing them to "get back home." For example, Yasir described his mother's involvement in family therapy as a transformative process that highlighted significant changes in his behaviors. He stated:

> It's helpful to know that my mom has been by my side the whole way through…, she's participating and engaging. I know she wasn't doing that from the beginning but it was so joyful and happy for me to know that she's still my mom. I'm gonna love her no matter what and that I could tell her anything about anything that happened to me or something and let her know.

Elijah also described the influences of his mother's involvement in family therapy as having a promising impact on their relationship. He was able to highlight how his "mom actually trying" has transformed his own behaviors towards family therapy. He now shows more care, interest, consistency, and investment in the therapy process. He attributed these changes in himself to the changes that he has noticed in his mother, in reference to her participation in family therapy and the progress they have made toward treatment goals. He clearly stated at the end of the interview, that family therapy in the RTF was "the best thing that ever happened to me…as it helped my mom understand that I am ready to be home with her. Basically to open my mom's eyes that one, she can't live without me, and two that she do love me, for once."

Theme 5: Views on Racial Inequalities & Injustices

The fifth main theme that emerged from the data analysis described the participants' *views on racial inequalities and injustices* that they have experienced and/or

observed. The following four subthemes were noted within theme five: *(1) "make nothing in life…;" (2) "they are racist…;" (3) racial comparisons between Blacks and whites; and (4) experiences with racial oppression.* Overall, the majority of the study participants (11 out of 15) were able to describe their experiences in a racial context. For these participants, who described their experiences from their racial locations, they were able to conceptualize how their racial background, as Black, contributed to the social disparities among Blacks and whites. Yasir provided an example on how he is perceived as Black (male) who will "make nothing in life:"

> Some people expect me not to make nothing in life. I mean our race be doing a lot of bad stuff and not good stuff. We're making our race look bad because we're in and out of jail and we're killing each other. They probably expect us to do the same things- like sell drugs out of our house.

Andre further sheds light on how Blacks are viewed negatively in society. He described his experiences in the RTF as "a life learned lesson but it's not good." His experiences in being Black were described as: "I think they just want to make money off us. They're always waiting for a Black person to do something stupid so we can be in place like this and they're making money off us." When Andre was asked to elaborate on who "they were," he identified "you know, different places like this…, judges…, facilities…, jails…, all types of places." He further reported that he felt racism contributed to Black people (kids) being in these facilities, highlighting the subtheme of "they are racist." He reported:

> They are racist; like people think you bad because you Black and stuff like that. I see a lot of Black people here…, it seems like Black people are making them right and its making it seem like they are meant to be here from the things they do.

Khalil also described his experiences as being Black by having a "discount for you in the real world…, it already works against you…, being Black and intelligent is already two things that the man doesn't want to see." Likewise, when questioned about how race may influence his experiences, Jaquan described his experiences in the RTF in comparison to his white counterparts, providing an example of the racial comparisons between Blacks and whites subtheme:

> Cuz I don't get treated like the whites. Like this white nigga- this white young boy (inserted name) on my unit. He not here, like his family put him in here. He gets treated different. From staff they don't, but certain people, yeah he do. Because the young boy gets (home) passes. His family takes him out whenever they want cuz they put him in and I be hat'in cuz I don't get passes every week.

When Jaquan was asked to explore more in depth about his understanding of these differences, he reported: "he gets treated better cuz he white and I'm Black… it's because I'm on probation." Jahmir also reported: "it's kinda stereotypical, but Black people are more likely to end up in placement or locked up than any other races are. I don't know. I believe it too sometimes. A lot of staff say it too, like because you're…, I mean it kind of shows, I come here and mostly everybody here is Black, African American." Similarly, Deshawn describes his views on how the legal justice system treats Blacks versus whites:

> There are more Black and Hispanics here (RTF) than whites. To be honest, I think white people get away with too much. Like that Trayvon Martin death, it was a

> white person that shot him. The security guard didn't get charged for it. I see it all the time… I seen so many Black people on probation. I know some white people that got probation, but most white people that you come across, they don't have probation. They don't have nothing; won't even have a charge probably…they are racist.

Equally, Sarena described her experiences as being Black, in comparison to her white counterparts, who are admitted to the RTF. She discussed how race influences her daily experiences:

> I think being Black influences everybody…, I mean it's more African American in bad facilities like this. You don't get too many whites, I guess. Like there is a difference between Black and white (in here). And when I see a Black girl walk through the door, I already know- just like a lot of people- it's not my intention to judge someone on how they look and you shouldn't but that's what they do. So if I see a Black girl walk in this door- either she got into a fight, she done stole something or she did that. If I see a white girl- oh she's MR, she's mentally retarded. Not like that, but she's here for self-harming, and that's how it is…we don't get too many white people in here for fighting. Only Black people are here for aggression, for drugs, for going through real things and going through a struggle. White people, they got it easy and that's just how it's always going to be.

More so, Aaron was able to describe his *experiences with racial oppression* within the legal system. Due to his involvement with the juvenile justice system, he has been attending court hearings, in which he has observed his father being treated differently due

to racial inequalities. This is evident through the following descriptions of his experiences:

> My judge is white and he doesn't care about what we say. Our voice doesn't matter when we in court. Like when my dad tries to talk to the judge and tell him all the things he has in place for me, he just cuts him off. He don't listen to him. He says- oh next court date. He don't listen at all.

Lastly, Jalecia described how the consequences of certain decisions and/or behaviors look differently for Black kids (people), as they are often prejudged by others on the basis of their skin color. She highlights her experiences with racial oppression, as a Black female adolescent:

> I feel like being as though I'm Black, it's just like people look at us differently. Like- you're Black. You're just going to act dumb so I might as well send you to placement- when that's not always the case. Some of us don't really act like that…some of us really do want to change and I feel like people just look at us like because I'm Black, I'm going to act a way and they have a stereotype of how they believe I'm going to be. Sometimes, I just feel like that impacts the way we face our consequences.

Theme 6: Experiences with Trauma & Loss

The sixth and final main theme that emerged from the data analysis described the participants' *experiences with trauma and loss*, both inside and outside of the RTF. The following three subthemes emerged within this theme: *(1) re-traumatization in the RTF; (2) experiences with tangible losses; and (3) experiences with intangible losses.* As the participants discussed their experiences in the RTF, on a day-to-day basis, they described

the challenges they face on their assigned units (floors). Darnell provides an example of how his peers further experience re-traumatization in the RTF. He described how his roommate experienced trauma before his admission to the RTF, which ultimately impacted their relationship on the unit. He reported:

> When I first got here, I didn't like it because my roommate, before he came here he got shot in the face, so he had some problems. Then whenever he would take this anger out, he would try to go after me and we would get into a fight. Then when we got into a fight, he would yell because he'd hit me first and then I'd try to explain it to the staff before they put me in a restraint. I would always get in a restraint- and then I wasn't able to tell my story because they would never come and process expect for once. Then when I told them they started to put him in restraints too even though he was shot.

Darnell further went on to state: "I had conflict with them (other peers) because they would think they were the head of the unit because they bigger. They go after you and try to make you flinch or hit you somewhere where it hurts." Similarly, Sarena described her own challenges in the RTF, while highlighting the importance of behavioral influences of her peers. She stated:

> It's just hard being in a facility with other kids that have the same problem that you have. You exposed to things that you shouldn't see or a child shouldn't see. Everyone adapts to the things around them and you adapt to things which aren't good…. it's just like say you can't put two suicidal people in the room…. like two drunk people can't drive… that's not a good outcome, so why would a bunch of behavior kids in the same facility that acts the same and take off each other, like

> follow reach other… like I don't know…. I just think it's hard because it's more drama; it's more fights; it's more bullying. I've been in placement where girls want to fight you all day, that's nothing to me.

The participants used words, statements, and phrases such as "I see a bunch of bullies in here," "the kids used to bully more often," "Black girls jumping white girls," "white kids on the floor call us niggers," "fights in the facility," "making fun of each other," "a bad place to be in" and "kids running their mouths." A very few participants indicated that residential staff engaged in "bullying" behaviors as well, as "they criticize you and think they are better than us."

Furthermore, all participants described their experiences with tangible and intangible losses as a result of being admitted to the RTF. Tangible losses included being physically "away from loved ones," "being stuck in here," "away from people that we love," "going in and out hospitals," "sent me to another placement" and being "locked away" in the RTF. All study participants provided descriptions of the intangible losses they have experienced as a result of their RTF admission. Nadir provided an example of the intangible losses that he has experienced since his admission to the RTF. He stated: "there's no freedom. You can't piss when you want… you can't eat when you want… you can't do nothing you want to do." He further goes on to describe his views on reasons that may lead to placement in the RTF:

> Cause they dumb as shit. Doing dumb stuff in the streets… some of 'em dumb and some of 'em not. Sometimes they don't got no family to go to, Sometimes DHS puts them here. It's not just a residential treatment for people that's getting locked up- the judge sent them here. It's for people that's getting locked up, for

> people that don't got no homes and some of them, they parents put them here. It's not that we want to be here; we don't want to be here. If I could leave, I'd walk out this mutha fuckin' door right now.

Other participants described their experiences as being "locked away from people we love," "trying to fix what we lost," "not being home with your family for holidays," "not having a mom figure around," "being out with your friends and doing big things" and "what has happened in the past…, fix your pain." More specifically, in discussing intangible losses, a few participants highlighted relational problems with their mothers, who were "not there for them." For example, Elijah openly described his relationship (or lack thereof) with his mother. He reported:

> She wasn't there for me, especially when I needed her for a lot of things. She wasn't there to help me through the pain that I was having at the moment or at any of them. She wasn't there to let me be a kid. She made me grow up to be a teenager when I was like six, maybe seven. She…, so I really didn't have a childhood. We never had fun when we was kids… my mom was always working, doing something. I don't trust my mom because she wasn't there. She wasn't really a mom to me and she was supposed to be, in my eyes, she was never there to help me through the trauma that I was having.

Table 4.9

Emerging Themes and Subthemes of Study

Major Themes	Sub-Themes
Views on Receiving Family Therapy in the RTF	Part of Treatment in the RTF Discharge from RTF Positive Experiences in Family Therapy in the RTF

Therapeutic Alliance & Relationship with RTF Therapist	Previous Negative Experiences in Family Therapy Positive Attributes Describing Relationship with their RTF Therapist Validation & Acknowledgement of Experiences by RTF Therapist
Developmental & Cognitive Shifts in Self	Changes in Views on Family Therapy Willingness & Desire to Change Own Behaviors Self-Motivation Towards Achieving Future Goals Influence of Parental Involvement & Engagement on Own Behaviors Restrictions in Mobility as a Result of RTF Admission
Treatment Goals in Family Therapy in the RTF	"It's my behaviors that put me in here…" "I want to go home…." Effective Communication & Appropriate Self-Expression Emotional Regulation & Management Developing Healthy Family Relationships Using Empathy to Understand Others' Experiences
Views on Racial Inequalities & Injustices	"Make nothing in life…" "They are racist…" Racial Comparisons Between Blacks and Whites Experiences with Racial Oppression
Experiences with Trauma & Loss	Re-traumatization in the RTF Experiences with Tangible Losses Experiences with Intangible Losses

4.5.2 Data Analysis Steps

Data analysis was conducted on the semi-structured interviews by employing the following four steps: *(1) bracketing; (2) analyzing; (3) intuiting; and (4) describing* (Wojnar & Swanson, 2007). The bracketing technique, also known as *epoché or phenomenological reduction*, was used in order to maintain authenticity of the participants' lived experiences (Crewell, 2007; Gearing, 2004; Richards & Morse, 2007; Saldana, 2013; Wojnar & Swanson, 2007). Bracketing involves consciously and actively "stripping" away prior experiential knowledge and biases, so that the researcher can examine the phenomena with a fresh set of eyes (Gearing, 2004; Giorgi, 1999; LeVasseur, 2003; Tymieniecka, 2003).

Step One: Bracketing the Data

Bracketing was the initial step in the analysis process. Bracketing was essential to the data analysis process in this research study, as the researcher had previously worked as a clinical therapist with the RTF population. In this role, she provided individual, family and group therapies to the youth and their families. The researcher assumed the "being-in" stance to immerse herself in the participants' world by listening deeply and attentively to their personal experiences with the phenomenon. Additionally, the researcher utilized the technique of *ideal* bracketing, which was the most appropriate method for this transcendental phenomenological study. Ideal bracketing allowed the researcher to exclude all internal and external suppositions and/or biases that could have influenced the results of this study.

Bracketing took place during the data collection and data analysis process, by the researcher writing her reflections, observations and confusions after each interview in a designated dairy. In addition to reflective journaling, the researcher consulted with the research consultant on a regular basis to assist with the bracketing process. This helped the researcher further identify and expand her views, highlighting both internal and external assumptions and/or suppositions that could have influenced the descriptions of the phenomenon under study. Internal suppositions include personal knowledge, history, culture, experiences and values, while external suppositions are centered on the history, definition and other macro-environmental factors that relate to the phenomenon (Gearing, 2010). Table 4.10 (below) provides examples of internal and external assumptions, biases, and/or suppositions noted in memos by the researcher.

Table 4.10

Internal & External Suppositions of Researcher

INTERNAL SUPPOSITIONS	EXTERNAL SUPPOSITIONS
• Therapy in the RTF is ineffective and "not working"; • Youth who are being provided therapy do not take treatment "seriously," hence "they are doing it because they are mandated to do so"; • Therapy is more behaviorally focused, rather than trauma-focused, despite a systemic shift to trauma-informed care; • Youth have a difficult time relating to their therapists, due to differences in demographics; • Issues with socio-cultural trauma are not being addressed in therapy; • Girls are more likely to engage in therapy and utilize it to bring about "changes"; • There is a distinct difference between treatment modalities being utilized with the residential and clinical teams in the RTF; • Family therapy is mostly provided by non-trained family therapists, which questions the effectiveness of family therapy in the RTF; • Family therapy takes place scarcely in the RTF due to limited family participation.	• Race plays a significant factor in the lives of African American/Black families in treatment; • Stigma around mental health impedes on utilizing treatment in the RTF; • Intergenerational patterns of "mistrust" of the system is passed down from parents to children; • Youth are re-victimized in the RTF due to further exposure to traumatic experiences, such as bullying; • Family members are not able to attend sessions consistently due to socio-cultural issues, such as economic deprivation; • These youth and families are "labeled" as non-compliant, unresponsive, and "really not interested in changing"; • Majority of the youth in RTFs have other system involvement; • Therapists who are not trained in family therapy cannot provide appropriate family therapy interventions; • Clinical interventions do not address issues relating to socio-cultural trauma; • RTF youth have high rates of recidivism due to ineffective treatment.

Step Two: Analyzing the Data-Colaizzi's 7-StepMethod

For this study, Colaizzi's (1973) method was utilized for *analyzing* the data. This seven step process included*: (1) reading and re-reading the participants' descriptions of the phenomenon; (2) extracting significant statements and/or quotes that concern the phenomenon; (3) formulating meanings for those significant statements and/or quotes; (4) categorizing the formulated meanings into clusters of themes that are common to all participants; (5) integrating the findings into exhaustive descriptions of the phenomenon;*

(6) validating the findings by re-interviewing some participants and (7) incorporating any changes suggested by participants into the final descriptions of the phenomenon (Colaizzi, 1973). The above noted steps are highlighted below to provide thorough details on the completion of data analysis for this dissertation study.

2.1: Reading and re-reading the participants descriptions of the phenomenon

The researcher reviewed all 15 transcriptions on an ongoing, as needed basis, during the data collection and analysis process. The researcher began reading the transcripts once the first 5 interviews were completed with participants. This was necessary to assist the researcher in identifying, labeling and organizing the data in "codes" (Bloomberg & Volpe, 2012; Richards & Morse, 2007; Saldana, 2009, 2013). Hence, the first step involved reading each transcript individually, once it was received from Fingers4Hire Transcription Services. After the first read, the researcher re-read each transcript, while highlighting specific "areas of interest" to re-visit in the third reading.

The third round of reading consisted of noting specific quotes, phrases, words and/or statements pertaining to the participants' experiences in family therapy in the RTF. The researcher continued reading and re-reading each transcription until she became familiarized with each participant's individual experiences with the phenomenon. The process of *horizontalization* was utilized in this stage. Horizontalization allowed the research to browse through the data, while highlighting important statements, sentences, phrases and/or quotes that provided an understanding of the participants' experiences in family therapy in the RTF (Creswell, 2007; Moustakas, 1994; Saldana, 2013). This step was repeated for the remaining 10 transcripts, for participants 6-15. It is important to note

that the researcher began analyzing the transcriptions for the last 10 participants on a weekly basis, as the interviews were conducted and audio files were transcribed.

2.2: Extracting significant statements and/or quotes that concern the phenomenon

The second step consisted of extracting significant statements and/or quotes from each participant's transcription that concerned the phenomenon. In determining what statements and/or quotes were significant in this research study, the researcher used the method of *repetition* (Bloomberg & Volpe, 2012; Creswell, 2007; Flood, 2010). Each of these important statements and/or quotes are outlined in step 4 (see below), while discussing how the themes and subthemes emerged from the data.

2.3: Formulating meanings for those significant statements and/or quotes

The third step consisted of formulating meanings from the significant statements and/or quotes that were extracted previously from the 15 transcriptions. In doing so, the researcher began to outline significant statements and/or quotes that had similar meanings, into an organized list. Once the list was developed, the researcher identified and highlighted words that were repeated in the transcriptions that linked to the items on the list. The researcher continued this process by re-reading the statements and/or quotes to verify that each of them were consistent and representative of the experiences of each participant. For each list of similar statements and/or quotes, the researcher formulated meanings that assisted in the process of developing clusters of subthemes that were common to all or most of the participants. The 24 subthemes that were developed provided qualitative data on the 6 major emerging themes.

2.4: Categorizing the formulated meanings into clusters of themes that are common to all participants

The fourth step included categorizing all the statements and/or quotes common to all or most participants into main themes. Each major theme developed through the formation of subthemes, which were categorized from a smaller, condensed list of statements and/or quotes. The six themes that emerged from the subthemes include the following: *(1) views on receiving family therapy in the RTF; (2) therapeutic alliance & relationship with RTF therapist; (3) developmental & cognitive shifts in self; (4) treatment goals in family therapy in the RTF; (5) views on racial inequalities and injustices; and (6) experiences with trauma and loss.* The following are examples of re-occurring significant statements, phrases, and/or quotes made by the participants pertaining to the 6 themes and its relative 24 subthemes.

Theme 1: Views on Receiving Family Therapy in the RTF

1.1 Part of Treatment in the RTF

- part of the rules here
- treatment process that is required
- it (family therapy) helps in getting discharged
- following the rules
- you just doing it (therapy) so you can get out of the place
- you usually do not care about the rules
- they talk (therapist & parent) and I agree with everything they say
- to help y'all get through the treatment
- talking about the rules
- expectations and regulations
- how I will act when I go home
- I have to do it because it is part of therapy here
- certain things you have to do

SIGNIFICANT WORDS: *rules, treatment, required/requirement, discharged, part*

1.2 Discharge from RTF

- going home on passes
- me going home
- getting discharged from here
- help me get out of this system
- helping me get back to my family
- it's helping me get home passes
- get me home to see my friends and hang out
- I'm just trying to go home
- how to act when I get home
- I looked at some of the stuff that I do in here is not worth not going home
- how I act when I go home on passes

SIGNIFICANT WORDS: *home, passes, discharge, back*

1.3 Positive Experiences in Family Therapy in the RTF

- being helpful
- helping people do what they want
- helping people succeed
- to help you through the pain
- get you through the process of healing
- person that is going to be there when you need them, to understand you
- being more open-minded
- gaining trust and being honest
- opening up and communicating
- dealing with family issues and problems
- help you in getting closer to family
- expressing my feelings and emotions
- learning to walk away
- listening to each other

SIGNIFICANT WORDS: *help (ing), being (something)*

Theme 2: Therapeutic Alliance & Relationship with RTF Therapist

2.1 Previous Negative Experiences in Family Therapy

- feeling unheard
- feeling like the therapist was not listening
- didn't feel like anybody was really listening to me
- the therapist did not understand them
- the therapist did not really care
- the therapist wanted to talk about what issues that he thought we needed to work on
- he was guiding me instead of me guiding myself
- I didn't get a lot of time to voice my opinions and talk about what I wanted to talk about
- feeling misunderstood
- feeling unheard in therapy at other places

SIGNIFICANT WORDS: *unheard, listening, understand (misunderstood), talk*

2.2 Positive Attributes Describing Relationship with their RTF Therapist

- earning our trust before anything else
- actually took the time to get to know us and what we are working with
- tried to understand it in our eyes….like point to point
- want us to succeed in the future and they are not just saying it
- I believe that for my therapist it is not just the paycheck
- she actually earned my trust
- not a lot of people earn that trust from me because I have trust issues
- I don't have any problems opening up to her (therapist)
- I can talk to her (therapist) about anything and not have a problem
- I can be honest with her
- I can trust her (therapist), so I'd have to say really good
- she (therapist) always has something that can help me
- she (therapist) was willing to listen and help me

SIGNIFICANT WORDS: *trust, help*

2.3 Validation & Acknowledgement of Experiences by RTF Therapist

- understanding me
- being helpful in therapy
- giving advice on how to handle a situation
- listening to me
- being supportive
- having someone to talk to
- helping me go home
- tried to understand it in our eyes, like point to point
- being honest and open
- helping me tell my mom things
- taking my side
- helping my grand mom see what she is doing wrong

SIGNIFICANT WORDS: *help (ing), listen (ing), understand (ing)*

Theme 3: Developmental &Cognitive Shifts in Self

3.1 Changes in Views on Family Therapy

- me caring more now
- actually wanting to do it, not just wanting just to get it over with
- actually being consistent in doing it (therapy)
- I actually want to do it (therapy)
- I wanted to go home
- it's human... I mean I feel normal... It's not an un-normal thing
- It's a lot of people out there that do therapy, especially family therapy
- I don't really have a problem with it (family therapy) …, it don't feel weird at all anymore
- I thought I had better things to do than that (therapy)
- I thought it was weird
- I thought people would think I was weird because I had to go to family therapy
- I thought about myself before

- I was only thinking about myself and how I would look if I went to family therapy
- I wasn't thinking about the outcome of going to family therapy. ..like I probably wouldn't be here right now
- I probably would be home because I probably would've got what I needed done and I probably would've had a better functioning family
- therapy has helped me think about all the important stuff instead of all the negative stuff

SIGNIFICANT WORDS: *want(ing), weird, better, myself*

3.2 Willingness & Desire to Change Own Behaviors

- the things I've realized from being away from home for so long
- me just growing up basically
- since I've been out the house and away from my home, I've had a little bit more freedom to think
- more time to realize what I'm doing that's wrong and stuff like that and actually helping out
- me being away from home
- actually wanting me to go back home
- the people I lost helped me grow up
- learning how to do things on your own instead of having somebody to help you
- I started to realize at some point I'm going to have to tell people what I'm going through and stop holding everything in
- I took it more serious than I did a lot of other times
- I just try to change on my own; like while I'm in here I gotta look at things differently

SIGNIFICANT WORDS: *away, home, help(ed)*

3.3 Self-Motivation Towards Achieving Future Goals

- it's been a life learning experience being in the facility
- it's just like I'm a young man and I'm growing up so I've got to make better decisions

- I've got to make better choices in life that will help make it better for me and my family
- you can take what they say and make something of it in the real world or you can just be a bum on the street without a family
- I want to make something out of my life
- I want to be there for my family just like they were there for me
- I want to take care of my mom just like she took care of me when I was little
- making progress in my life
- having somewhere to go
- I'm getting older
- I need to start taking things more serious

SIGNIFICANT WORDS: *life, family, better, decisions, choices*

3.4 Influence of Parental Involvement & Engagement on Own Behaviors

- seeing that my mom actually trying in therapy
- it's not more what happened to me… it's more of what I seen that changed me
- the changes in my mom and the changes in my family
- when I was at home before, my mom just wouldn't ask me what's wrong and stuff but now she does
- we talk about what happens…before I would get mad and shut down…, just say less things at certain times if they need me to talk
- we set up a time to talk when I'm going home
- I'll talk more at home with my mom or my dad
- when me and my dad were together…we talk all the time
- it was happening before but it was like he would just talk the whole time and every time I wanted to say something or say what I had to say, he would just cut me off…so I would just be like, "alright"
- now we are listening to each other, that's helping your relationship be more positive

SIGNIFICANT WORDS: *change, talk*

3.5 Restrictions in Mobility as a Result of RTF Admission

- since I've been out the house and away from my home…I've had a little bit more time to realize what I'm doing that's wrong and stuff like that
- me being away from home…, actually wanting me to go back home
- you can't piss when you want, you can't eat when you want and you can't do nothing you want to do
- there's no freedom here
- it's the type of place that me or any other person show not be in because they should be home with their family during the holidays or regular days
- you should definitely be out with your friends doing big things…,not kid things
- we're locked away from people we love
- it's not that we want to be here; we don't want to be here; if I could leave, I'd walk out of the mutha fuckin'in door right now
- my freedom
- being free from here

SIGNIFICANT WORDS: *free, freedom, back, home, people (family/friends)*

Theme 4: Treatment Goals in Family Therapy in the RTF

4.1 "It's my behaviors that put me in here…."

- not following rules
- people telling me what to do
- I just wanted to do what I wanted to do
- I got sick of people telling me what to do, when to do it…, I was like fuck it, I just do what I want
- when I be bad…she (therapist) tells me how many write-ups and why did I do bad and all that
- following after people…acting immature, doing dumb stuff, and being at the wrong place at the wrong time
- myself, my attitude, my anger, my aggression, my disrespect; that kinda stuff
- I started doing bad things; I started acting worse
- hanging around the wrong people

- being around the wrong kids
- I kept bottling things up and exploding on people
- we all the same basically…, we all did something to get in here
- fighting my little sister
- ditching school and hanging out the wrong crowd
- trying not to disrespect her (mom) or fight and stop sneaking out
- I used to sneak out all the time and don't come back for like two days
- banging on stuff and getting loud or kicking stuff
- fighting in school
- me coming in the house late
- having people over the house without permission
- fighting my sisters and my brother
- smoking marijuana
- mainly behaviors in school; skipping school; I don't go to school
- not following curfew; me coming in the house late
- to figure out the behaviors I was doing wasn't right and if I did it later on in life, I wouldn't be able to get the help I needed
- problems in school
- the way I talk to people, my anger, being disrespectful and different stuff
- I was fighting and doing whatever I wanted
- cursing at staff, being disrespectful

SIGNIFICANT WORDS: *rules, bad, wrong, fight (ing), wanted, do, school, disrespectful, sneak (ing), behaviors*

4.2 "I want to go home…."

- going home on passes
- me going home
- getting passes
- getting discharged from here
- help me get out of this system
- helping me get back to my family

- probably to get us back home…,it's helping me get home passes
- get me home to see my friends and hangout
- I'm just trying to go home
- my goal is to go back home
- I looked at some of the stuff that I do in here is not worth not going home

SIGNIFICANT WORDS: *home, passes, going, back*

4.3 Effective Communication & Appropriate Self-Expression

- talking to my brother
- talking to my family
- getting along with my family
- talking about my history of trauma
- conversations that were not happening/opening up
- how to overcome stress
- open up more in my family
- learning to walk away/coping skills
- getting my feelings out
- how to cooperate with my coping skills
- help to talk about my feelings
- getting shit off my chest
- help you learn how to express yourself
- creating space to talk
- learning to get along with my family
- help communicate with my family
- let my mom know what's going on
- to let each other know what's going on
- I talk about how me and my mom should handle certain situations
- trying to work on communicational skills…I guess I've opened up more to my dad and I never really used to
- find the right time to say something or not
- helps you communicate and change your mindset

- my mom sitting back, letting me talk and hearing what I'm saying

SIGNIFICANT WORDS: *talking, open-up, feelings, getting along, family*

4.4 Emotional Regulation & Management

- using coping skills when I'm angry
- when I'm irritated and I want to talk to someone
- help to talk about my feelings
- getting shit off my chest
- get your anger out
- help you learn how to express yourself
- not to get angry when I don't get my way
- help you cope with your emotions
- help me calm down so it doesn't escalate
- I end up getting mad and walkin' out
- I kept bottling things up and exploding on people
- I actually opened up about some of my feelings
- you have to chill with your emotions
- you can't just snap

SIGNIFICANT WORDS: *angry (anger), irritated, mad, calm, emotions, feelings, what's going on, talk, communicate, family, open-up*

4.5 Developing Healthy Family Relationships

- discussing problems and what has happened
- getting along with my family
- fix what has happened in the past and move forward
- issues you have with your family
- get closer to my family
- help communicate with my family
- let my mom know what's going on
- to let each other know what's going on
- to have a better bond

- trust and communication, that's really it right now
- how me and my mom can handle certain situations
- getting along with family
- trusting each other more
- I've gotten a little closer to my family
- things I want to resolve with my family
- I used to couldn't stand my mom and now I do
- just to be able to tell my mom anything
- to help your family get on the right track and to keep it running

SIGNIFICANT WORDS: *close(r), family, trust, getting along*

4.6 Using Empathy to Understand Others' Experiences

- putting myself in other's shoes
- learning empathy
- getting to know other people and how they feel
- use empathy to put myself in their shoes…, to not judge them
- looking at different points of views
- work on different perspectives
- see from her side and my side

SIGNIFICANT WORDS: *empathy, shoes, different, other*

Theme 5: Views on Racial Inequalities & Injustices

5.1 "Make nothing in life…"

- some people expect me not to make nothing in life
- they're always waiting for a Black person to do something stupid
- we're making our race look bad
- we're in and out of jail
- we're killing each other
- like selling drugs out of our house
- I mean it's more African American in bad facilities like this

- like your Black…, you're just going to act dumb so I might as well send you to placement
- Black kids get put in places like this
- I think a lot of white people look down on us
- Black people are more likely to end up in placement or locked up
- Black kids get put in places like this

SIGNIFICANT WORDS: *make (making), nothing, race (Black), bad, look, place(ment)*

5.2 "They are racist…"

- they racist…. like people think you bad because you Black and stuff like that
- they don't have nothing... won't even have a charge probably… they are racist
- I think being Black influences everybody
- being as though I'm Black, it's just people look at us differently
- I feel like people just look at us like because I'm Black, I'm going to act a way
- they have a stereotype of how they believe I'm going to be
- staff is racist
- kids on the floor that are racist…they call us niggers
- I think a lot of white people look down on us
- people get discriminated against because they Black
- poor African Americans, they get discriminated against

SIGNIFICANT WORDS: *racist, bad, look, discriminated, against, because…Black*

5.3 Racial Comparisons Between Blacks and Whites

- it's (being Black) a discount for you in the real world
- it (being Black) already works against you
- cuz I don't get treated like the whites
- he (white peer) gets treated different cause his family put him in here
- the young (white) boy gets passes, and I don't get passes every week
- he gets treated better cuz he white and I'm Black…, and it's because I'm on probation
- it's kinda stereotypical, but Black people are more likely to end up in placement or locked up

- to be honest, I think white people get away with too much
- I seen so many Black people on probation… I know some white people who got probation, but most white people that you come across, they don't have probation
- it was a white person who shot him (Trayvon Martin)…, the security guard didn't get charged for it…, I see it all the time
- white people, they got it easy and that's just how it's always going to be
- there is difference between Black and white in here
- only Black people are here for aggression, for drugs, for going through real things and going through a struggle
- if you see a white girl (in here)…, oh she's MR… she's here for self-harm and that's just how it is
- we don't get too many white people here for fighting
- if I see a Black girl walk in this door- I already know- either she got into a fight, she done stole something or she did that
- consequences are different for Blacks than whites
- you're already a Black male, so that's a negative
- by them being white, they got more leeway
- they have a stereotype of how they believe I'm going to be
- I just feel like that (being Black) impacts the way we face our consequences

SIGNIFICANT WORDS: *treated, different (difference), probation, get away, easy/leeway, stereotype (stereotypical), consequences, white (people)*

5.4 Experiences with Racial Oppression

- my judge is white and he doesn't care about what we (Dad & I) say
- our voice doesn't matter when we in court
- he (judge) don't listen at all
- sometimes, I just feel like that (being Black) impacts the way we face our consequences
- Blacks getting killed out in the streets
- I don't be treated like the whites
- Black kids get put in places like this

- they used to treat us like slaves... like shit… that's show history created the society
- white people, they got it easy and that's just how it's always going to be
- Black people are judged everywhere
- like we're going to be judged no matter where we go
- I think a lot of white people look down on us
- consequences are different for Blacks than whites
- people get discriminated against because they Black
- poor African Americans, they get discriminated against
- white kids on the floor…, they racist…, they call us niggers every day

SIGNIFICANT WORDS: *discriminated, against, consequences, treat(ed), judged, Black*

Theme 6: Experiences with Trauma & Loss

6.1 Re-traumatization in the RTF

- it's really hard being in here… I see a bunch of bullies in here
- staff criticize you… they think they better than us
- making fun of each other
- kids running their mouths
- my roommate would fight me…take his anger out and go after me
- they think they were the head of the unit because they bigger
- try to hit you somewhere where it would hurt
- the kids used to bully more often
- kids talking about each other
- black girls jumping white girls
- history of trauma
- what happened to me and trauma
- white kids on the floor… they racist… they call us niggers everyday
- fights in the facility… a bad place to be in

SIGNIFICANT WORDS: *bully (bullies), trauma, kids, fight/hit, hard*

6.2 Experiences with Tangible Losses

- I've been out of the house … away from my home
- the people I lost
- there's no freedom here
- you can't go anywhere
- we locked away
- locked away from people that we love
- my freedom is taken away
- send me to another placement
- cops booked (locked) my brothers
- going in and out of hospitals

SIGNIFICANT WORDS: *away, freedom, home/house, locked*

6.3 Experiences with Intangible Losses

- my freedom…being free from here
- you can't piss when you want; you can eat when you want
- there's no freedom here
- be out with your friends doing big things
- not being home with your family during the holidays
- we are locked away from people we love
- people I have lost
- mom and dad not being around to reach wright from wrong
- not having a Mom figure around
- Mom wasn't by my side the whole time
- it's not like you can express how you feel... they just tell you
- trying to fix what you lost
- because she (Mom) used to put everybody else first before her kids
- Mom and Dad arguing all the time
- what has happened in the past… fix your pain
- Mom not there to help me

- what happened to me and all that

SIGNIFICANT WORDS: *freedom, want, people, Mom (not around), Dad, lost, happened*

2.5: Integrating the findings into exhaustive descriptions of the phenomenon

The fifth step in the analysis process is integrating the findings of the study into thick, detailed descriptions. This step entails providing exhaustive "textural" and "structural" descriptions of the phenomenon. Textural descriptions of the data highlight *what* the participants' actually experienced as it relates to the phenomenon (Bloomberg & Volpe, 2012; Creswell, 2007). Structural descriptions define *how* the participants experienced the phenomenon in terms of the condition, situation, and/or context (Bloomberg & Volpe, 2012; Creswell, 2007). These textural and structural descriptions help formulate a final, rich description of the phenomenon that fully captures the *"essence of the experience"* for all participants. Textural and structural descriptions are thoroughly discussed later in this chapter, under the final fourth step (describing the data) of the Colaizzi's method. The essence of the experience is also presented at the end of the data analysis section.

2.6: Validating the findings by re-interviewing some participants

Follow up interviews were conducted for all 15 participants. The second interviews took place in the RTF, within 2-4 weeks of the initial interviews. Only two second interviews were completed 2-3 months later, as those two participants had been discharged from the facility. Those two interviews were completed in the community in the participants' home. These second interviews helped to validate the findings of the study, by clarifying and confirming the responses that the participants provided during the initial interviews. Each participant was able to confirm the following results:

- Their (participants) views on family therapy have changed through their experience in family therapy in the RTF;
- Family therapy has been helpful in achieving their (participants) goals in treatment (see above goals that were noted in step 4);
- They (participants) engaged in family therapy mainly to get discharged from the facility, however found it to be useful in developing a closer relationship with their family members;
- They (participants) were able to connect with their RTF therapist, as s/he was understanding and validating of their experiences;
- Being locked in the facility, with their freedom being taken away, helped them (participants) self-reflect on their future (goals);
- They (participants) have learned to understand other people's perspective, which has allowed them to be empathetic;
- The participants described their experiences in a racial context, in which they felt "being Black" influenced their daily lives, as it pertained to the social inequalities and injustices that take place inside and outside of the RTF;
- Last, the participants discussed their experiences with trauma and loss (both tangible and intangible), which were heightened as a result of their RTF admission.

2.7: Incorporating any changes suggested by participants into the final descriptions of the phenomenon

All 15 participants took part in the second interview, as it was a requirement set beforehand to receive the $25 reward. Some participants provided more input and insight into their responses, therefore the researcher was able to incorporate those changes in the final descriptions. All 15 participants agreed with the descriptions that were presented to them by the researcher. The two participants that were discharged from the facility provided additional data on their experiences in family therapy outside the facility. Of relevance was that both of them indicated that they continue to work on similar goals in

family therapy, with their family-based treatment team, while they are utilizing the skills that they learned in family therapy in the RTF. Family-based services (FBS) program is the highest level of care, falling under community-based services (CBS). The majority of the youth who are discharged from RTFs are stepped-down to FBS.

Step Three: Intuiting the Data

The third step involves *intuiting*, which simply requires the researcher to make a conscious effort to understand the lived experiences of the participants (Wojnar & Swanson, 2007). The researcher took several precautions during the intuiting step. First, in her previous role as a clinical therapist in the RTF, the researcher has experienced the phenomenon first-hand (from a therapist's perspective). She has had the opportunity to merge into the lives of the youth in the residential setting, which has provided "live" observational data on the youth's experiences in family therapy in the RTF. She has also provided family therapy to the RTF youth and their families, which has assisted her in understanding the complexities of family therapy in the RTF.

Second, the researcher imagined and placed herself in the "participants' skin" by setting aside her own assumptions, biases, and personal and professional experiences that were formed during her tenure as a RTF clinical therapist. She made a conscious effort to fully understand the experiences of the youth by listening proactively and attentively during the interviews. For example, in her role as a RTF clinical therapist, the researcher experienced family therapy to be unhelpful to the youth and their families, due to minimal progress in treatment. The researcher assumed that the participants' experiences would be similar, however majority of the participants indicated that family therapy in the RTF has been very helpful for them.

Similarly, other presuppositions were noted before, during and after the data collection and analysis process, so that an accurate account of the phenomenon could be presented. The researcher also engaged in regular conference calls with her research consultant during the data collection and data analysis process. The researcher received guidance and support in generating accurate accounts of the participants' experiences in family therapy in the RTF through critical reflections and discussions. Last, reflecting journaling and memoing helped the researcher identify her own previously developed biases, assumptions, and suppositions, so as not to influence the descriptions of the "actual-lived" experiences of the participants.

Step Four: Describing the Data- Textural and Structural Descriptions

The last step in the data analysis process is *describing*, which entails providing both textural and structural descriptions of the phenomenon (discussed in step 5 above). The next section provides textural and structural descriptions for the 6 main themes of the study, along with discussing sociocultural contexts that are significant to the findings of study. This is followed by the formulation of a composite description of the "essence of the phenomenon," which outlines the *final description* of the phenomenon.

Theme 1: Views on Receiving Family Therapy in the RTF

Textural Description: *What did the participants experience in family therapy in the RTF?*

When the participants talked about their *views on receiving family therapy in the RTF*, they used positive words to describe those experiences. They stated that family therapy was "part of the treatment" in the RTF, which ultimately helped them "get discharged from the facility." All participants engaged in family therapy because they

wanted to “go home “and “get passes” on the weekends. Depending on how successful the home passes went, it prepared them to get “out of the RTF.” Most participants’ views on receiving family therapy in the RTF were also positive, as family therapy taught them to be “open-minded” and “communicate more openly” in sessions. They were able to develop “trust” with their RTF therapist, as s/he “helped” them “express themselves” appropriately in family therapy sessions, so that they could have a “closer relationship and/or bond” with their family members.

Structural Description*:* *How (in what context) did the participants experience family therapy in the RTF?*

All participants described their views on receiving family therapy in the context of the RTF setting. They discussed their experiences in family therapy in other treatment settings that were challenges and “unhelpful”, as they felt “unheard” in sessions. The family therapy that took place in the RTF was different, in the sense that they were able to “learn” coping skills and different ways to “express themselves” in front of their family members (who were participating in family therapy sessions). The participants also discussed how they use the learned skills when they “go home on passes,” because they have had positive experiences in family therapy in the RTF.

Theme 2: Therapeutic Alliance & Relationship with RTF Therapist

Textural Description: *What did the participants experience in family therapy in the RTF?*

When the participants discussed their experiences in family therapy in the RTF, they highlighted the importance of the *therapeutic alliance and relationship with RTF*

therapist. They used words such as "helpful," "trust," "honest," "open," "guiding" and "listening" that contributed to them having a relationship with their RTF therapist.

Structural Description*:* *How (in what context) did the participants experience family therapy in the RTF?*

The participants described their experiences in family therapy in the RTF in the context of their relationship with their RTF therapist. They described this relationship as having positive attributes because they were able to "trust" and be "open and honest" with him/her. The participants also described this relationship as a "process that took time," because their RTF therapist "earned" their trust and showed "care" and "understanding" for them. This positive therapeutic alliance developed because they felt "heard" as their therapist "listened to them" in family therapy sessions.

This relationship was formed as a result of their therapist validating their "lived" experiences in the RTF, along with acknowledging the challenges they have experienced in being involved in the different SOC. Specifically, they developed trust in their RTF therapist because s/he was able to "take their side" and also "help" their family members understand their perspectives and "points of view." The participants' positive alliance and relationship with their therapist in the RTF played a significant role in the progress they made in achieving their goals in treatment and "getting home passes."

Theme 3: Developmental & Cognitive Shifts in Self

Textural Description: *What did the participants experience in family therapy in the RTF?*

When the participants talked about the *development and cognitive shifts in self*, they were able to identify "changes" they experienced as an outcome of being admitted to

the RTF. They described changes in how they viewed family therapy in the RTF, as "wanting to do it now." Previously, they felt that family therapy was "weird" and "un-normal," which contributed to them "not caring to do it." The participants also discussed "only thinking about themselves," and "worrying about people thinking it (family therapy) was weird," which did not allow them to participate freely and openly. They further stated that they started engaging in family therapy in the RTF because they "wanted to go home," along with the realization that family therapy would be "helpful" in changing their family dynamics.

Structural Description*:* *How (in what context) did the participants experience family therapy in the RTF?*

The participants described the developmental and cognitive shifts that they experienced in family therapy in the RTF in the context of the losses that they have experienced in their lives. They highlighted how their "freedom" has been taken away since they have been admitted to the RTF. They have experienced both tangible and intangible losses as a result of being "stuck" in the RTF. Most participants discussed "being away from their families and friends" helped them realize that they needed to make "changes in their life," especially if they wanted to have a "better life." They began to recognize what they were doing was "wrong" and that they needed to make better "choices" and/or "decisions" in their lives.

The lack of mobility and freedom that stemmed from being confined in the RTF gave them a new perspective on life. These experiences, in the RTF, forced them to "grow up" and "make progress," so that they can "get out and go home" to be with their families and friends. The loss of physical mobility significantly contributed in their desire

and willingness to change their (maladaptive) behaviors, hence motivating them to achieve their "future" goals. These future goals entailed "taking things more seriously," and thinking about "my future" and "my life."

Lastly, the participants described the developmental and cognitive shifts in themselves in the context of the changes they recognized in their relationship with their family members (parents). They described the influence of parental involvement and engagement in family therapy in the RTF as playing a very important role in the changes in their behaviors. They observed their parents "trying in therapy" and "listening to them" in family therapy sessions, which led to a "closer relationship" with each other. The participants discussed how the skills they learned in family therapy were being utilized at home during visits and passes. The losses that both the participants and their family members experienced opened up a door for them to work on developing a stronger, healthier relationship with each other.

Theme 4: Treatment Goals in Family Therapy in the RTF

Textural Description: *What did the participants experience in family therapy in the RTF?*

All participants described their goals in family therapy in the RTF. Each of them reported that their treatment goals entailed changing the "behaviors that put them in the RTF," and "going home and getting discharged." These main goals were achieved by them making a conscious effort to work on "communicating," "talking," and "listening" to each other "openly" in family therapy sessions. Other treatment goals in family therapy in the RTF consisted of learning new ways to "express" themselves, managing their emotions, developing healthy family relationships and using empathy to understand

others' perspectives. Overall, accomplishing these treatment goals assisted the participants in getting discharged from the RTF, as the clinical team recognized the behavioral changes that were made by the youth.

Structural Description*:* *How (in what context) did the participants experience family therapy in the RTF?*

All participants discussed treatment goals in family therapy in the RTF in the context of the behavioral changes that are needed for successful discharge from the facility. They used words like "my behaviors," "hanging around wrong people," "doing wrong things," "fighting," not following rules," and "wrong place, wrong time," as behaviors that led them to the RTF. They also discussed the need for them to change the way they "deal" and "cope" with their "feelings" and "emotions," so that they can "express" themselves in a positive, healthy manner. These changes in their behaviors have helped them develop a "better, closer" relationship with their family members, as they are able to "empathize" with them. In sum, their behaviors led them to the RTF and will "get them out" as well.

Theme 5: Views on Racial Inequalities & Injustices

Textural Description: *What did the participants experience in family therapy in the RTF?*

In discussing their views on *racial inequalities and injustices,* the participants described the "stereotypes" that exist in the society pertaining to being Black. The participants reported that they often felt "white people look down on them because they are Black." They have received messages about "not making nothing in life" because "most people (whites) think we will do bad things." In highlighting those "bad things"

they provided examples of engagement in aggressive behaviors (fighting), drug use and distribution (using and selling drugs out of the house), getting locked up (placement or/and jail) and killing each other on the streets. Overall, the participants explicated noted that "white people were racist." The participants described these experiences both inside and outside the RTF, with white peers calling them "niggers."

Structural Description*:* *How (in what context) did the participants experience family therapy in the RTF?*

The participants described their views on racial inequalities and injustices in the context of the larger systems of care that are involved in their care. They discussed how the consequences for their white peers look different because "they are white and we are Black." The participants highlighted how "white people have it easy…, they have more leeway… and they get away with things easily…, they don't have probation (as much as Black people)." Specifically, the participants addressed how they are viewed in society as "bad" kids, hence "they should be put away in placement" because "they will make nothing in life." A few participants also discussed how they are labeled negatively, while their white counterparts get the "benefit of the doubt" as being mentally retarded (Hardy & Laszloffy, 2005). The participants were able to clearly identify how their racial social locations contributed to the unfair mistreatment that they receive in society by being locked away in facilities, to include RTFs, hospitals and jails.

Theme 6: Experiences with Trauma & Loss

Textural Description: *What did the participants experience in family therapy in the RTF?*

When the participants discussed their *experiences with trauma and loss*, they provided descriptions on the "bullying" that occurs in the RTF. The participants reported they often discuss their experiences with being "picked on" or "being bullied" by their peers in family therapy sessions. They reported that it is very "hard" to be in the RTF because "it's a bad place to be." The bullying that occurs in the RTF took the form of both verbal and physical aggression. The participants admitted on engaging in physical altercations (fights) with other peers, in addition to "talking about each other." These experiences further added to the history of trauma and loss the youth have experienced prior to being admitted to the RTF.

More so, the participants identified their physical removal from their homes and communities as a form of tangible loss they have experienced. They also described experiences with intangible losses, which included: being away from loved ones, missing holidays, losing time in the facility, not being able to be a child, not having a mom around; trying to fix what you have lost and what has happened in the past. All these examples provide evidence of the participants' experiences with trauma and loss within the RTF and larger society.

Structural Description*:* *How (in what context) did the participants experience family therapy in the RTF?*

The study participants described their experiences with trauma and loss in the context of their "freedom" that was" lost" and "taken away" as a result of being "locked away in the facility." They experienced further re-traumatization in the RTF due to the increased bullying incidents in the facility. The participants further experienced losses

(tangible and intangible) as they are "way from their loved ones," hence they are "losing time being the RTF."

4.6 Additional Topics of Significance

An important focus of this study was to explore and understand the experiences of the participants in different social contexts, to include race, gender, class and age, as it pertained to the phenomenon. The sampling questions (Appendix B) were designed to assist the researcher in understanding the participants' experiences as lower-income (class), Black (race), male and female (gender) adolescents (age 15 and 16). The participants easily described their experiences in a racial context; however they showed limited understanding of the questions that related to their experiences in other social contexts, to include gender, age, and class. In fact, class was the most difficult to discuss during the interviews as the participants did not identify as lower-class. In fact, only 1 participant identified as lower-class, while 2 identified as upper-class, and 12 identified as middle class. This will be addressed in Chapter 5 as part of the discussion on participants' misidentification of their socioeconomic status (SES).

Due to the limitations on data collection in these areas, certain topics emerged; however, their mention was not sufficiently frequent to form themes and/or subthemes. Despite the participants' challenges in understanding some of the interview questions, specifically relating to describing their experiences in different social contexts, it is important to note the experiences of those who were able to provide some insight into the phenomenon from a socio-cultural perspective.

Race

Despite the emerging theme of racial inequalities and injustices among Blacks and whites, a small number study participants (4 out of 15) reported that race did not influence their experiences in or out of the RTF. When questioned about his experiences as Black in the RTF, Jaleel responded by stating "there's nothing to tell, there's nothing to say about it. That's just my skin complexion. If I was purple, it would make no difference." He was further asked to elaborate on how his experience may be similar or different to peers of other racial backgrounds. He continued to report: "I think it's the same. Here (RTF) I don't see no kid getting treated differently, like if I was white or Black…. That (race) has nothing to do with me being in placement."

Nadeer also expressed that the RTF had a "mixture of kids…, half of 'em Black and half of 'em white. We all are the same people. We all got the same skin color. It's equal to me. It's simple as that." He further went to state that "I'm not racist. I'm cool with everything, being Black or white. I'm saying my experiences is cool. I don't got no problem with nobody." Nashay had similar views in that she reported "I don't really see no race in here because mostly everyone in here is different races…, like Puerto Rican and Indian, like different races like that." Elijah's statements also highlight the participants' views on race having minimal influence on their experiences in the RTF: "I would say it's like 5% of the kids in here admitted because of their race…, the rest of them are basically in here because they did something…, for drugs, self-harm, attempted murder, whatever they did." These statements provide some explanations on the beliefs and views that it's primarily their "bad behaviors" that resulted in the consequence of them being admitted to the RTF.

Gender

Very few (4 out of 15) male and female participants were able to reflect on their experiences in the context of their gender. Through their observations, along with their own experiences, they were able to distinguish some differences between males versus the females in the RTF. For example, Khalil described his experiences as a male in the RTF:

> It's tougher…, more discipline…, it's harder, stricter. More structure I mean. It's not as easy. You have to chill with your emotions, you can't just snap. You got to hold it in but still make sure that you do what you supposed to do.

Aaron also described his experiences as a male in the RTF:

> Guys act immature when they are around a bunch of guys…, they fight more when they are around each other. Our pride always gets in the way…, like say if he calls you a name or something; you have to prove him wrong by fighting or saying something back or something like that.

He further continued to compare his experiences as a male in the facility with the female youth: "females don't deal with pride and respect issues as much as males." Similarly, Andre also addressed the issue of pride for males in the RTF: "I see a whole bunch of (Black) males arguing and fighting each other and being rude to each other. I don't like that because we should stick together. People's pride. People let their pride get in the way." Nashay also concluded her experiences as a (Black) female to be challenging. She stated:

> It's really hard to be in here. Not just because I'm Black. It's certain things you have to do to be like the best person in here…, to get staff to recognize you and to talk to certain people. It's a lot of bullying going on in here. It's just a lot.

In examining gender differences between males and females in the RTF, Nashay reported that she felt boys were given far more leverage in getting away with things. She quoted "the boys got more leeway because they boys and they gon' do boy stuff. But girls, staff is harder on us because they want us to do better." She further goes on to state "girls go through the same situations, like they mostly here for the same reasons and we feel like we can talk to each other because we went through the same things." This statement highlights the support that females may be providing to each other during their tenure in the RTF, while the males are focusing on their "pride," which does not allow them to connect with each other.

All 4 participants (above) described their experiences in the RTF as a male or female. These descriptions shed some light on the relationships that males and females develop during their adolescent years. All expressed that bullying was an issue that haunted young males and females in the RTF; however, males tend to engage in bullying behaviors, when they feel "disrespected and dissed," which hurt their "pride." On the contrary, females showed more sympathy towards each other, as they are able to relate to each other's experiences. Overall, both males and females agreed that it is "harder, tougher and stricter" in the RTF.

Age

Roughly half of the participants (7 out of 15) were able to discuss their experiences in family therapy in the RTF as adolescents. Some described those

experiences as being an “eye-opener” as they have “grown and matured” from being admitted to the RTF due to the losses they have experienced. For example, Yasir stated:

> I’m young and I’m in placement…. I’m aging in placement. That’s time that I could be spending with my family and that’s years I never get back in life as I’m growing up. I have people growing up and having birthday parties at home, spending time with their family at home. That’s something I’m not going to get back in life because I’m growing up and I ain’t have a lot of stuff to do because I was in placement.

Ciara also described her experiences with maturity as she got older:

> Um yeah…, I used to set stuff on fire. I used to ditch school. I smoked one time, only one time and that’s when I fought my mom’s boyfriend- one time. I just look back on everything, or when I’m sitting in the cafeteria, I just look at all the kids and then look at the younger kids that are in here and be like…. I used to be acting just like them; fighting, don’t care, don’t do nothing, and then one day I just changed. My attitude or when I got really angry I would talk about it with one girl I’m really close with.

Khalil also highlighted how his admission to the RTF changed his views:

> It’s helping me grow up. Yeah because you’ve got to make a choice, like if you want to be here you keep acting goofy or do you want to leave and go home. If you want to leave and go home you have to mature and force yourself to do things you wouldn’t normally do.

Jalecia described her experiences as those that have been positive because she gained insight into her own (wrong) behaviors. When questioned about her age, she indicated:

> I'm young. I don't really mind it because I made dumb decisions when I'm young. I don't really feel no type of way, I feel like (RTF) was actually better for me because it kind of helped me. It kind of made me realize things and kind of made me see things a little differently and how I look at things because I think I'm young and I get away with things. But in all reality I can't and I'm getting older and this behavior is getting old.

Furthermore, some of the participants discussed the developmental changes that took place with them that contributed to the utilization of family therapy in the RTF. They began to realize that they needed to use therapy to "help" them. As Andre stated:

> It's been a life learning experience for me because to figure out that behaviors I was doing wasn't right and if I did it later on in life, I wouldn't be able to get the help I needed because people wouldn't really care because I'm an adult…they wouldn't care but as a child, they want to help you.

Aside from highlighting the significance of the developmental and cognitive shifts that he experienced during his stay in the RTF, he showed insight in articulating how his age plays an imperative role in being given second chances in this society. Sarena also expressed similar views on how her age (as an adolescent) provides her with more opportunities to make mistakes and learn from them. She stated:

> I probably didn't understand nothing that they was saying when I was younger. I'm still young like not too young but not too old. If you're too old, you don't got much to go on and too many decisions, I got a lot of making up. Now it's like this age, its ok to make mistakes…, like you get more chances and you get more time to make decisions.

She further goes on to report that she has learned a lot more as she transitions into young adulthood. This is evidenced by the following statement: “I mean it’s better (now) because I know more things. Like I know my rights. Like I know I don’t have to do certain things. When I was younger it was no say, like they can do what they want, give me medicine…, l don’t know.”

Last, two participants discussed their experiences in family therapy in the context of being the “child” in the therapy room, as they are participating in sessions with two other adults (parent and therapist). They both described how they have felt “left-out” or “unheard,” as the adults in the room make the “final decisions,” with little room for them to express themselves. Aaron stated:

> It feels like they more mature than me and they know more than I do and they can help me with my problems. And they probably been through certain things that I’ve been through so that can help me with it…. I feel a little left out sometimes because I am younger and I can’t do certain things that adults can do. I could express myself as long as I’m being respectful, but I can’t make all the decisions. My dad has to make certain decision for me because I’m too young.

Like Aaron, Jalecia also stated:

> Sometimes, I feel like I can’t speak or I can’t get my point across. Sometimes, I may feel like when am I going to get to talk? When are y’all going to stop talking? Like I may be a kid but I want to speak too, I want to get my point too. Sometimes it helps and sometimes it doesn’t.

Yasir also expressed his challenges in speaking up in family therapy with his Mother. He reported:

> Well it's hard. Sometimes I be scared to really say what I really want to say because I don't want to say something and they take it the wrong way. So sometimes I just try to get it out the best way I could so she (mom) could understand it.

Class

Class was vaguely discussed by the participants in the study. The majority of the participants were not able to provide detailed descriptions of their experiences in family therapy in the RTF in the context of their SES. Most participants (12 out of 15) identified as middle-class, despite falling in the bracket of lower income (see Chapter 5 for further discussion on class misidentification). They reported that they did not "think" about class or issues relating to financial resources available to their family. For those participants (3 out of 15) who were able to provide some insight into their experiences in family therapy in the RTF, they highlighted how class impacts the ability for youth and families to engage in treatment proactively. When questioned about her experiences within the context of her SES, Jalecia reported:

> Class-wise, I probably say I guess lower. I mean I've never been poor, I just don't get to have everything I want but I have everything I need. It doesn't really bother me. I'm not really hyped over money because I know I'm taken care of and I have nothing really to worry about. I'm not rich, but I'm not poor.

Sarena also provided some details on her understanding of class, as it related to the experiences of the RTF youth. She indicated:

> I feel like the majority of everybody in here is coming from lower class. Because some people don't have the money to come up here and see their kids. Some

> people don't have cars and they catch the bus and that can wear them out more and make them angrier that they've got to catch the bus to get up here to do things to get the money to get up here. It can make you want to give up.

As evidenced by Sarena's statements, it is clear that the limited financial resources for some families did not allow for active participation in treatment. Last, Andre discussed how his "upper" class affords certain privileges to him. He stated:

> I'm higher than a lot of the kids here because I have more stuff. I have family, cousins, aunts, and uncles that come up here to visit and I look at some of the rest of them and they don't have nobody coming up here to see them and nobody to bring them nothing.

Despite the lack of recognition of the influence of class, in the lives of the RTF youth, the descriptions provided by these 3 participants highlight the significance of addressing class issues in treatment as SES may present as a barrier to participating in family therapy.

It is also important to note here that, even though most of the participants' self-identified as middle-class, they were able to identify their peers in the RTF, as lower-class. During the interview, the participants were asked to examine the class differences of the RTF residents, at which time, they reported that their peers appeared to be from the lower-class because they don't "have certain things" and "their family members are not able to come visit them frequently." Further research should focus on the identification of class-status for minority youth, specifically to understand the challenges around the accuracy of self-identification as lower-class. It would also help to understand the markers that identify class-status of adolescents.

4.6.1 Client-Therapist Relationship in a Sociocultural Context

The main goal of this study was to understand the experiences of lower-income Black adolescents in family therapy in a RTF. As mentioned previously, the interview questions attempted to understand those experiences in different social contexts, to include race, gender, class and age. As the researcher utilized open-ended semi-structured questions, the participants were able to discuss other areas that were not necessarily being examined in this dissertation study. It is important to highlight those topics as they are significant in understanding the participants' experiences in family therapy in the RTF. As some of the participants discussed their experiences through a socio-cultural lens, they were also able to describe the importance of their therapist's cultural background, in terms of race, gender and age.

Race and gender were most frequently discussed by the participants during the interview. Of those participants (5 out of 15) who discussed the race of their therapist, there was a clear division on whether race "mattered or not." Both Jahmir and Jalecia did not feel that race was not an important factor in their client-therapist relationship. Jalecia reported:

> I think it really doesn't affect me whether her race is Black or white or anything. If I feel comfortable talking to her, I feel like I'm fine. It doesn't really matter what race she is and it don't really bother me no type of way. It doesn't make her different or make anything different between me and her…. It has worked out fine for me. It doesn't really do anything to me that we're the same race because we're both still humans and we're both females. I feel like that's what more affects me is being around a female and having an understanding with her. My therapist's

> race doesn't really influence me to do better. I think gender is more important than race.

Likewise, Jahmir also expressed the same views about his female therapist. He stated:

> She might know, but just because she hasn't been through what I've been through doesn't mean she can't understand it. She can still understand it. She doesn't have to go through it to understand it…, she doesn't need to be Black, she doesn't need to go through what I've gone through just to understand. I feel that you don't need to go through what I went through just to understand. You can understand without going through all of that or without being in my position.

On the contrary, three participants felt that the race of their therapist was significant for them. When questioned about her experiences with her "biracial" therapist, Sarena reported:

> I mean if I had a white therapist, I wouldn't think that she would understand me because it's easy. I'm not saying it's easy for them because they're human too, but by them being white, they got more leeway. I'm just going to say that I wouldn't prefer a white therapist because I don't think they would understand me. I mean they smart but I just don't like to be around people that look down on me. I think a lot of white people look down on us.

Elijah also expressed similar thoughts about feeling connected to his (young) Black female therapist. He stated:

> Because they either didn't go through it. Like I said, let's say if I was talking to a white lady, a white woman and she was older than me/an elderly woman, and I told her some of the things I go through in life with the police this, this and this,

> what happens? She would try to give me some kind of advice but at the same time she wouldn't know exactly what to say because she didn't go through or it didn't happen to her because she's white…. Yes, she understands how I would feel if somebody calls me a nigger or something that or be racist, basically.

Last, Aaron vividly described how his experiences in therapy with previous white therapists have been. He stated: "the difference is that white therapists, they try to say it's my diagnosis, but my Black therapist is saying that I'm just doing things and it could be fixed and is just a label."

More specifically, gender preference for a female therapist was noted by both male and female participants. Like Jalecia, who expressed gender being more important than race for her, Jaquan and Elijah also preferred a female therapist. Jaquan stated: "Because I can talk to her more. I'm on a unit with all boys so I don't like talking to boys every time." Deshawn felt differently as he preferred a male therapist "because they probably understand it better and understand more. Since they a male, they probably understand more of where I come from."

Final Description: The Essence of the Experience

Overall, the experiences of the participants demonstrate that, although several of them viewed participation in family therapy as a technical or perfunctory requirement for being granted privileges to be released from the RTF, they and their families benefitted greatly from it. These benefits occurred despite the complicating issues of perceived racial injustice and acknowledged trauma and loss, both of which manifested within and outside of RTF confinement. Indeed, the benefits of family therapy were a direct result of the open, validating and authentic relationship the participants were able to develop with

their respective RTF therapists. Family therapy facilitated participants' critical self-reflection, which engendered meaningful cognitive shifts in how they assessed their own negative decisions and behaviors.

As a result of these shifts, participants began to develop a more positive, productive self-concept and were determined to correct those behaviors that precipitated their admission to RTF. The participants were also able to highlight their experiences through a racial lens, which entailed providing descriptions on the injustice and inequalities they have experienced and/or observed as a result of "being Black" in society. The social contexts of gender, age and class all played some role in how the participants' interpreted their socio-cultural positions in family therapy in the RTF, vis-a-vis their respective RTF therapists and society at large.

4.7 Trustworthiness of the Study

Transcendental phenomenology research focuses on trustworthiness rather than on validity and reliability, which is the goal of quantitative research (Bloomberg & Volpe, 2012; Creswell, 2007). To evaluate trustworthiness for this study, the following four integrated concepts were used to validate the findings: (1) *credibility*, (2) *transferability*, (3) *dependability, and (4) confirmability* (Bloomberg & Volpe, 2012; Creswell, 2007; Guba & Lincoln, 1998; Patton, 2012; Richards & Morse, 2007).

4.7.1 Credibility

To achieve credibility in the data findings, the researcher reviewed each participant's background before interviewing them. She documented any potential bias, assumptions and/or suppositions that may emerge during the interview in a designated diary. After each interview, the researcher also included her observations, reflections and

confusions in her dairy. To increase credibility, the researcher conducted second interviews with each of the 15 participants, specifically to verify the results of the descriptions that were formed during the analysis process. Additionally, the researcher utilized the technique of *triangulation*, both *data triangulation* and *investigator triangulation* (Patton, 2002).

Data triangulation took place by using different data sources, such as reviewing the information provided on the demographic surveys and the transcriptions of the semi-structured interviews. The researcher also verified the accuracy and consistency of the information received from these two methods with the information that was provided in the psychiatric evaluations of each participant. The researcher also utilized investigator triangulation by debriefing regularly with her research consultant and methodologist to help clarify the results of the data retrieved from the study participants. Both these individuals assisted the researcher in examining the results of the data analysis, and in making sure that the descriptions of the phenomenon were free of the researchers own biases, assumptions and/or suppositions.

4.7.2 Transferability

Transferability parallels the criterion of generalizability, as it focuses on whether and how the methodology of the study in question allows the researcher to identify substantial similar phenomena in similar contexts (Bloomberg & Volpe, 2012). Transferability was achieved in this study through the formulation of thick descriptions from the responses of the participants. Through prolonged field work, during the initial and second interviews, the researcher was able to place herself in the RTF environment, allowing her to experience the “lived” experiences of the participants that were described.

Additionally, the researcher was able to thoroughly understand the lived experiences of the participants, as it relates to family therapy in the RTF, because she had previously worked in the RTF as a clinical therapist. To ensure that the researcher did not impose her own biases, assumptions, and/or suppositions from her previous experience, she bracketed throughout the data collection and data analysis process. Overall, transferability was achieved by making sure that the descriptions that were formed were representative of all of the participants' experiences with the phenomenon being studied.

4.7.3 Dependability

Dependability parallels the criterion of reliability and tracks the processes and procedures used to collect and analyze the data (Bloomberg & Volpe, 2012). Dependability was achieved through tracking, recording and following Colaizzi's (1973) seven steps of data analysis, which have been thoroughly discussed earlier in this chapter. These steps provided clarity on how the descriptions of the phenomenon were formed throughout the data analysis process. The researcher completed an "internal audit" during the analysis process to validate the coherency and consistency in the data. The internal audit consisted of reviewing the transcripts and audio-tapes to make sure that other themes (meaning units) did not emerge from the data. This also provided an opportunity for the researcher to highlight any significant information that may have been overlooked in the process.

Furthermore, dependability was achieved through an "audit trail" that was completed by the research consultant. Completion of the audit trail entailed making sure the transcripts were independently coded, so as to find any inconsistency in what the researcher described versus what the research consultant observed, defined and described.

The review of the participants' transcripts by the research consultant assisted in inter-rater reliability, which enhanced the dependability of the research study.

4.7.4 Confirmability

Finally, the technique of confirmability was used to achieve trustworthiness of this research study. Confirmability refers to the extent the descriptions of the phenomenon can be confirmed by others who read the research results (Bradley, 1993). Simply put, confirmability implies that the findings of the study are the results of the data, and not the results of researcher subjectivity (Bloomberg & Volpe, 2012). In achieving confirmability, the researcher employed the bracketing technique, along with journaling and memoing throughout the research process. Bracketing took place during the data collection and data analysis process, by the researcher writing her reflections, observations and confusions after each interview in a designated dairy. This allowed the researcher to further identify and expand her views, highlighting both internal and external assumptions that could have influenced the descriptions of the phenomenon under investigation. Examples of internal and external suppositions were discussed earlier in this chapter. Member-checking (through second interviews) with each participant and (data and investigator) triangulation also helped attain confirmability of the study.

4.8 Conclusion

This chapter has presented the key findings of this transcendental phenomenological dissertation study. The six major themes and 24 subthemes were presented and explicated using quotes from the 15 male and female study participants. Vital demographic data that were gathered from this research study were presented in

both narrative and table forms. Then, the steps in the data analysis were laid out in detail to demonstrate the rigor with which the study was undertaken and to bolster the trustworthiness of the findings. Next, textural and structural descriptions were set forth to provide an overview of how participants experienced the phenomenon of family therapy in a RTF. This was followed by describing the "essence of the experience," with a *final description* of the phenomenon.

Furthermore, other emerging topics of significance that addressed the phenomenon through a socio-cultural perspective were highlighted in this chapter. While an overwhelming number of participants were able to situate their experiences within a racial context, far fewer acknowledged the salience of gender, and fewer still were aware of the effects of age and class. Finally, the four methods of trustworthiness that were utilized in this study were discussed.

CHAPTER 5: DISCUSSION

5.1 Overview of Chapter

This chapter examines the findings of the current study within the contexts of Narrative theory, Africana womanism theory and the multicultural perspective (MCP) framework. Overall, a discussion of the following topics will be presented here: (a) gaps in the literature, (b) connections to previous research, (c) significance of theoretical frameworks, (d) clinical implications, (e) study limitations, (f) recommendations for future research, and (g) final conclusions.

5.2 Gaps in the Literature

This study aimed to address the following gaps in the literature: (1) the dearth in the attention that is devoted to understanding the experiences of underserved populations, such as Black adolescents; (2) the availability of limited research addressing the mental health needs of the residential treatment facility (RTF) population from youth (client) perspectives; (3) inadequacies in research that examines the experiences of (Black) adolescents in family therapy in a RTF; (4) the lack of qualitative studies focusing on the needs of underserved populations; and (5) limitations in understanding the experiences of Black adolescents in family therapy in RTFs through a socio-cultural perspective.

This study addresses those gaps in various ways. First, the study was designed to elicit *descriptions* of the experiences of Black adolescents from their own perspectives. The open-ended questions in the semi-structured interviews facilitated this process. Second, the study's inclusion criteria focused specifically on adolescent minorities, 15 male and female participants, aged 15 or 16 years old, who self-identified as Black and African American. Furthermore, the inclusion criteria of having a minimum of 6 family therapy sessions and residing in the RTF for at least 6 months ensured that the

participants had significant exposure to the phenomenon being studied. It was essential that the participants met these two criteria, as it created a context for them to provide detailed descriptions of their experiences in family therapy in the RTF.

Third, the use of a transcendental phenomenological approach made it possible to develop comprehensive thick descriptions of Black adolescents' experiences in family therapy in the RTF, which were derived from the participants' own personal narratives. These specific descriptions provided insight into the following: (1) participants' views on receiving family therapy in the RTF; (2) their assessment of the development of a therapeutic relationship with their therapists in the RTF; (3) the influence of family involvement on the treatment; (4) the changes they encountered cognitively and developmentally; and (5) their understanding of how their social locations, specifically their racial background, impact their daily life experiences. Finally, the use of Narrative theory, Africana womanism theory, and the MCP as theoretical frameworks allowed for clear, concise interpretations of the research findings. These theoretical frameworks aided in the conceptualization of the participants' experiences in family therapy in the RTF through a socio-cultural lens.

5.3 Connections to Previous Research Studies

The research findings presented in Chapter 2 highlighted significant areas of interest pertaining to the mental health needs of today's youth. These areas included: (a) statistics on youth mental health diagnoses and treatment; (b) demographics of youth admitted to RTFs; (c) disparities in mental health treatment for underserved minority youth; and (d) the utilization of evidence-based family therapy practices with youth receiving mental health treatment. The data analysis of the demographic surveys and

semi-structured interviews from this study provided further evidence supporting previous research findings on the above-noted areas.

5.3.1 Statistics on Youth and Mental Health

About 50% of youth in the child welfare system have mental health problems and 67-70% of youth in the juvenile justice systems have a diagnosable mental health disorder (Stagman & Cooper, 2010; Warner & Pottick, 2003). Mental health problems tend to begin early in life, with onset occurring as early as 7 to 11 years old, and with average start of life-time mental health disorders by mid-teens (Behan & Blodgett, year; Children's Defense Fund, 2010; Kessler et al., 2007; Stagman & Cooper, 2010). Mental health problems, such as depression, anxiety, disruptive behaviors, substance use and eating disorders all impact the lives of the general youth population (Surgeon General Reports, 1999). The American Academy of Children and Adolescent Psychiatry (AACRC) has presented data on specific DSM diagnoses that are prominent in youth. These include conduct disorder, depressive disorder, eating disorders, attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD) and post-traumatic stress disorder (PTSD; AACRC, 2010; Merikangas et al., 2010). The most common disorders are ADHD, conduct disorder and mood disorders (Merikangas et al., 2010; Shabat et al., 2008).

The demographics of the 15 participants in this study had mental health diagnoses similar to those found in previous research. The mean age at which their first encounter with mental health treatment occurred was 8.9 years old. Conduct disorder was the most common diagnosis, with a prevalence rate of 73%. The next two most prevalent diagnoses were ADHD and PTSD, which included 47% of the participant population.

Forty percent of participants were diagnosed with disruptive mood dysregulation disorder (DMDD), 13% were diagnosed with depressive disorder and 6.7 % with mood disorder. It should be noted here that the diagnosis of DMDD was only recently included in the DSM-5. DMDD was incorporated in the DSM-5 to distinguish adult bipolar disorder from bipolar symptoms in children and adolescents. Under the new definitions, children with extreme behavioral dysregulation, without non-episodic irritability, no longer meet criteria for bipolar disorder (Regier, Kuhl & Kupfer, 2013). Cannabis use disorder was present in 20% of the study population. Last, the following disorders were prevalent in 6.7% of the participants: major depressive disorder (MDD), general anxiety disorder (GAD), reactive attachment disorder (RAD), obsessive compulsive disorder (OCD), and binge-eating disorder. All these psychiatric diagnoses have shown prevalence in the youth population (AACRC, 2010; Merikangas et al., 2010; Offord et al., 1986; Spady et al., 2005; Surgeon General's Report, 1999).

In examining the research on gender differences and mental health disorders, females show higher incidences in mood disorders, specifically depressive disorder (Carter et. al, 2003; Else-Quest et al., 2006). Conversely, males show high rates of behavioral disorders, such as conduct disorder and ODD (Carter et al., 2003; Connor et al., 2004; Else-Quest et al., 2006). This study had similar findings, with 88% of the female participants having been diagnosed with mood disorders. Three females were diagnosed with DMDD, 1 participant with depressive disorder and 1 with mood disorder. Conduct disorder, ADHD, and ODD presented significantly higher in the male participant population. Eighty-two percent of the male participants were diagnosed with conduct disorder, 55% of males were diagnosed with ADHD, and 28% of males were

diagnosed with ODD. Only 50% (2 out of 4) of the female participants were diagnosed with conduct disorder and 25% (1 out of 4) with ODD.

DMDD was only present in 33% of the male population and MDD with 1 male participant (11%). Contrary to the findings in previous research, substance use disorders were only found in males (Connor et al. (2004). All 3 participants who were diagnosed with cannabis use disorder were males. Eating disorder was present only in 1 female participant (25%). Likewise, comorbidity was evident in all 15 participants with each being diagnosed with 2 or more disorders. Despite the small sample size, the findings of this study coincide with previous research as it pertains to comorbidity in diagnosis with the youth residential population (Connor et al., 2004; Loeber & Keenan, 1994; Nelson et al., 2011; Nelson et al., 2012; Spady et al., 2005; Waxler et al., 2008).

5.3.2 Gender Disparities in RTF Admission

Male and female adolescents tend to be admitted to RTFs for different reasons. Generally speaking, the RTF youth population has been described as having severe emotional, behavioral and familial disturbances which often lead to treatment in out-of-home placements (Warner & Pottick, 2003; Zelechoski et al., 2013). Undoubtedly, these youth face a broad range of problems, which include maltreatment, neglect, disturbed family interactions, extensive histories of trauma exposure and underprivileged environments, all of which contribute to poor social competencies (Harr et al., 2011; Stagman & Cooper, 2010; Warner & Pottick, 2003; Zelechoski et al., 2013). Additionally, these youth are more likely to be involved in other SOC, such as the child welfare and juvenile justice systems (Stagman & Cooper, 2010). Youth who have

involvement in other SOC often do worse than those who have no involvement (Stagman & Cooper, 2010; Warner & Pottick, 2003).

Although all 15 participants were admitted to the RTF due to engagement in aggressive or assaultive behaviors towards others, male participants tended to be more physically aggressive. Incidents of aggression took place in social settings, including home, school and the community. Specifically, 8 out of 15 (53%) participants reported they were admitted to the RTF for reasons relating to "family problems." These included: running away and/or eloping from home due to family problems; threats to hurt family members (siblings, mother, mother's boyfriend and father); physical altercations with family members; and not following rules at home. Participants reported their "main" reason for running away from home was because they were "tired" of all the fighting at home and they wanted to "get away." These reasons also were related to issues with abiding by rules at home, as "they did not want to come back home."

It is important to note here that a large number of participants, 9 out of 15 (60%), reported incidents of physical aggression in the school. More specifically, 4 out of those 9 participants (44%) indicated that they were physically aggressive towards their teacher in the classroom. The same participants had legal involvement in the juvenile justice system for either simple or aggravated assault. All 4 of these participants were male. These results provide some understanding of not only the gender differences that exist in interpersonal violence, but may also explain the higher rates of legal involvement for males. Three out of the 4 female participants reported aggression within their homes towards other family members. These findings support previous research that females

show significantly higher rates of family psychopathology and conflict (Connor et al., 2004).

The data in Chapter 4 showed that a high number of the study participants had involvement in additional SOC. Only 3 study participants (20%) reported no involvement in other SOC. Eighty percent of the participants had either CPS or legal involvement. Regarding gender differences, males had a higher rate of legal (10 out of 11), and CPS (6 out of 11) involvement. The female rates were significantly lower, with 1 out of 4 participants involved in the legal justice system and 2 out of 4 female participants being involved with CPS.

Furthermore, males showed a higher frequency (6 out of 11) of being involved in both systems of care than females (1 out of 4). In cross-examining the data on CPS and legal involvement, a higher number of participants (10 out of 15) had legal involvement than participants (8 out of 15) with CPS involvement. The main reasons for legal involvement were: (1) assault (simple and/or aggravated) charges; (2) terroristic threats; (3) weapon-related incidents (i.e. threatening others with knife or scissors); (4) property damage and/or destruction (i.e. vandalizing, flatting tires); (5) robbery and/or burglary; (6) arson; and (7) drug possession and/or distribution. One male participant reported having charges for attempted murder. The 1 female participant who reported having legal involvement was charged with retail theft. Overall, these findings align with previous research conclusions that males are involved in the legal juvenile justice system at higher rates than females (Warner & Pottick, 2003).

Gender variation in reasons for admission to RTF was evident in other areas. Males tended to have more placements and greater rates of failure to adjust (FTA).

Participants who reported FTA, weapon related incidents, robbery/burglary and fire-setting as partly the reasons for their admission were all males. Only 1 male reported the current RTF as his first placement. Each of the remaining 10 male participants had a history of 1 or more admissions to other RTF placements. It appears that males may experience increased challenges in adjusting to residential placements than females. This finding is also consistent with previous research, which finds that youth in RTFs tend to have a considerable history of out-of-home placement (Connor et al., 2004). A greater percentage of female participants (25% female vs. 18% male) reported substance related incidents as a reason for admission. Suicidal behaviors (3 participants) and truancy (1 participant) were equally present in both male and female participants. Animal cruelty was the sole reason for admission for 1 female participant.

5.3.3 Socioeconomic Status (SES) Misidentification

Many participants misidentified their social class. As noted, 80% of the participants (12 total) self-identified as middle-class, with 13% (2 total) as upper class, and 7% (1 total) as lower class. Despite the majority of the participants' self-identification as middle-class, there was ample evidence to show that they were, in fact, lower class. The data on the funding sources for the study participants' placement provide evidence for their lower-class status. All 15 participants were funded through insurance providers who delivered behavioral health and substance abuse treatment through medical assistance's (MA) *HealthChoices Plan* of Pennsylvania (PA). MA, also known as Medicaid, is a public health insurance program administered by the state of Pennsylvania. MA covers many categories of people. These include children, adults, senior adults and individuals with disabilities. In order to be eligible for MA, individuals

must fit into one of the below listed categories, in addition to meeting other income and resource requirements (Wright, Coggins & Mita, 2015).

MA has three different categories for children. These include the following: (1) modified adjusted gross income (MAGI); (2) children with disabilities; and (3) children's health insurance program (CHIP; Wright, Coggins, & Mita, 2015). For the purpose of this study, MAGI and children with disabilities will only be discussed as it pertains to the study participant population. MAGI covers children with low-income families until the age of 19. The income limit varies with age and is compared to the federal poverty guidelines. The "children with disabilities" category provides coverage for children with severe disabilities and/or behavioral disorders. Children in this category must meet social security guidelines for having a "disability" and must meet income criteria of the child (not household) to be eligible for MA (Wright, Coggins & Mita, 2015). All of the 15 participants in the study were covered through MA because they met criteria either through MAGI or children with disabilities. Thus, it can be inferred that the study participants are, in fact, lower-class, rather than middle or upper-class as they self-identified.

More specifically, 12 participants (80%) were funded through Community Behavioral Health (CBH) because they resided in Philadelphia. Two participants (13%) were funded through Community Care Behavioral Health (CCBH) and 1 participant (6.7%) was funded through Magellan Behavioral Health (MBH) due to residence in another county. These three insurance companies are known to provide services to lower income individuals and families, as they have partnership with Medicaid programs in Pennsylvania. Also, the agency itself, as well as the RTF program in which recruitment

took place, have a reputation for providing behavioral health services to low-income families residing in Philadelphia and the surrounding areas.

Misidentification of socioeconomic status (SES) is actually a well-recognized phenomenon. A recent Pew Research Center (PRC) survey found that nearly 9 out of 10 people considered themselves to be middle-class despite their incomes languishing at or below the poverty line (Cohen, 2015; PRC, 2015). Overall, the results of the survey revealed that a large number of poor Americans consider themselves to be middle-class (Cohen, 2015; PRC, 2015). The survey concluded the following:

- 9 out of 10 Americans called themselves some version of "middle class;"
- 47% of Americans called themselves middle class;
- approximately 11% identified as upper middle class;
- 29% said they were lower-middle class;
- only 1% called themselves "upper class;
- 10% considered themselves "lower class" (PRC, 2015; Cohen, 2015).

Even more alarming is the fact that 87% of Americans categorize themselves as "middle class," even though the Census Bureau reports that 45.3 million Americans currently live in what is considered poverty (Kasperkevic, 2014; Novak, 2014). Thus, the fact that most study participants indicated "they get everything they want" and that individuals who get "everything they want are not poor," but supplementary financial evidence suggested that they were, in fact, poor, is congruent with previous research. Perhaps persistent episodes of devaluation and the accompanying reduction in self-esteem may also lead the participants to overcompensate by minimizing and/or refusing to acknowledge their own

poverty. Future research could focus on explanations (i.e. normalization of poverty) as to precisely why social class misidentification occurs in poor adolescent RTF residents.

5.4 Significance of Theoretical Frameworks

In applying the theoretical frameworks of Narrative theory and Africana womanism theory, as well as incorporating the core concepts of the MCP, certain themes emerged. The first theme was participants' *views on receiving family therapy in the RTF*. To be sure, a small number of participants appeared to be engaging in family therapy to solely meet the requirements of their treatment, so they could "go home and get discharged" from the RTF. However, a majority of the participants were fully committed to the therapeutic process and utilized family therapy as a means to develop healthy relationships with their family members, relationships that had been damaged as a result of interpersonal conflict. Participants demonstrated a sincere interest in: (2) externalizing their problems so as to disentangle their behaviors from their identities; (2) understanding that their antisocial behaviors are not essential and can be changed; and (3) re-authoring their stories so that they could acquire those life skills necessary to live pro-socially within their communities.

As a result of participants' commitment to developing new positive personal narratives, participants were able to proceed toward the following *treatment goals in family therapy in the RTF* (theme four): *behavioral management "(it's my behaviors that put me in here…"); discharge from the RTF ("I want to go home…"); eff*ective *communication and appropriate self-expression; emotional regulation and management; developing healthy family relationships; and using empathy to understand others' experiences.* Achieving these therapeutic goals ultimately helped them "return back home

to their families and communities," as they were able to engage in newly learned pro-social behaviors. Discharge from the RTF was determined by the clinical team, parents/legal guardians/care givers and other SOC which may be involved in the treatment process. Overall, the youth (and the family) must meet their treatment goals to initiate the discharge process, which is usually determined by behavioral improvements in the RTF with the youth and during home passes/visits on the weekends. The biweekly family therapy sessions allowed the family to report behavioral data and progress (or lack thereof) during the home passes/visits to the RTF clinical therapist.

Application of Narrative theory to the interview data shows that participants were able to externalize and re-author their personal narratives (stores). Through this reauthoring, participants learned to appreciate how removal from their homes and communities was a direct result of their own inability to develop age-appropriate social competencies. For example, the participants struggled to communicate in a positive, healthy manner, thus leading to anti-social behaviors. These youth showed limitations in their capacity to self-regulate (emotional dysregulation), which impeded on their ability to develop healthy interpersonal relationships.

Hardy & Laszloffy (2005) describe these experiences as the *loss of diminished function*, which refers to an individual's cognitive, emotional, and/or physical ability. Usually "when an individual suffers from diminished function, they experience the loss of one or some combination of their intellectual, emotional, or physical competency" (Hardy & Laszloffy, 2005, p. 88). Narrative theory provided the needed cultural context for participants to properly situate their loss of diminished function as being the direct result of their behaviors, but not a result of who they inherently "are." Consequently, we

can see how the externalization of Narrative theory and the social constructivist underpinnings of MCP converge in the process of re-authoring, in a manner that helps to shift the focus from the participants themselves as being problematic, to their *behaviors* as being problematic.

5.4.1 Experiences with Trauma and Loss

The process of forced removal from their homes and communities to be placed in a RTF underscores participants' *experiences with trauma and loss* (theme six). Because the Narrative approach is collaborative and values the opinions and experiences of the adolescent participants – opinions and experiences which participants often feel are *not* sufficiently valued because of their social locations – therapists' appreciation of episodes of trauma become central to the reauthoring process. For many participants in the present study, trauma and loss were culturally specific to poor urban Blacks, a cultural specificity that may actually heighten their sensitivity to trauma and loss.

Undoubtedly, much of participants' trauma and loss is exogenous to the RTF, resulting from the violent and tumultuous atmosphere that pervades many impoverished urban neighborhoods. However, the experiences of the RTF youth are all too often typified by re-traumatization *within* the RTF itself, through bullying behaviors exhibited by their RTF peers. In describing their experiences with re-traumatization in the RTF, the participants described numerous, almost daily, incidents of bullying that occurred on their designated floors by their peers. The bullying occurred in the form of both verbal and physical aggression. When Andre was asked to describe his experiences, as it pertained to the RTF environment (culture) and him being a Black male, he reported: "I see a whole

bunch of Black males arguing and fighting each other and being rude to each other.… I don't like it because we should stick together…, but people let their pride get in the way."

Darnell also described similar experiences of bullying in which he struggled to have a positive relationship with his roommate due to his physical aggression towards him. He stated: "my roommate got shot in the face and whenever he would take his anger out, he would try to go after me and we would get into a fight." The female participants described similar incidents of bullying in the RTF. Sarena reported her experience in the RTF to be "hard because it's more drama here…, it's more fights…. I've been in placement where girls want to fight you all day." The bullying narratives of Andre, Darnell and Sarena are clear examples of the re-traumatization experienced by the youth prior and subsequent RTF admission.

Ultimately, the data are unclear as to whether RTF re-traumatization behaviors such as bullying represent for Black youth: (1) outlier phenomena, in which case their impact upon successful achievement of therapeutic goals in negligible or non-existent, or (2) prevalent phenomena, in which case their impact upon progress could be significant. It is likewise unclear whether such behaviors are endemic to the RTF experience, and thus inherent and impossible to eliminate, or coincidental and capable of modulation or elimination. However, what is clear is that the phenomenon of RTF re-traumatization through bullying was thematically salient in the present study, as evidenced by participants' descriptions of its negative impact on their views of life in the RTF. Future research could focus on the potential correlation between RTF re-traumatization phenomena and the course and/or pace of progress toward treatment goals for Black youth in the RTF.

5.4.2 Tangible and Intangible Losses

In addition to the re-traumatization that the participants experience as a result of the bullying incidents in the RTF, they also described their experience with the continuation and/or exacerbation of both tangible and intangible losses. As discussed in Chapter 2, tangible losses occur in the emotional and psychological domains, while tangible losses have a physical, emotional and psychological component (Hardy & Laszloffy, 2005, p. 81). In practice, the source of the loss can be both tangible and intangible simultaneously. For example, all study participants described some form of loss(es) in their lives, which occurred both before and after their admission to the RTF. They described physical removal (tangible loss) from their homes and communities as very difficult because it "took away their freedom." They also discussed how their "removal" from their homes and "being away from their loved ones" impacts their level of engagement in family therapy.

While painful, these experiences pushed the participants to work on their treatment goals, specifically "changing their behaviors," with the anticipation to return home to their family and friends. Even those participants that noted that "they were fakin' it" highlighted how their lack of physical mobility and freedom contributed to their willingness to engage in the therapeutic process. Here, forced distance from family and friends represents a tangible loss because of the restrictions on physical mobility imposed by the RTF, restrictions that prevent involvement in enjoyable physical activities, perhaps such as partying or family meals.

It was clear from participants' narratives that distance from friends and families was also a significant source of intangible losses. Their intangible losses focused less on

the "things" and "events" themselves, and more on the emotional *meaning* of those things and events – for example, the emotional attachment to the attenuation of familial relationships and to the freedom of movement which they lack in the RTF. Unfortunately, all of these youth must obtain permission from "others" (the RTF Clinical Team) to remain connected with their loved ones. Those youth who have legal and/or CPS involvement must also seek approval to participate in scheduled home visits/passes. The inability to make decisions is a form of intangible loss that these youth and families experience due to involvement within different SOC. Descriptions such as "you can't piss when you want…, you can't eat when you want," are demonstrative of how Black RTF residents are denied seemingly mundane social privileges, privileges that are often taken for granted by individuals who do not carry the burden of the societal-induced devaluation that is experienced by the many Black urban youth who overwhelmingly populate RTFs (Hardy & Qureshi, 2012).

Without question, family was the focus of participants' intangible losses. In discussing their intangible losses, participants discussed how "they are not able to do normal things," and miss out on "holidays and regular days." The proper development of healthy family and peer relationships is critical during the adolescent years. Unfortunately, youth in RTFs report that they are "missing out" on those experiences, as they often find themselves missing the holidays, birthdays and other celebratory events due to their confinement in the RTF. Some participants also discussed the history of their relationship with their parents, specifically mothers, providing examples of intangible losses they experienced through neglect, abandonment and separation. For example, Elijah discussed how his relationship with his mother was problematic, as he was very

angry and resentful towards her. This was a result of the "abandonment and pain" he experienced as a child, which led to the development of "trust and honesty issues," between he and his mother. He clearly stated:

> She wasn't there for me, especially when I needed her for a lot of things. She wasn't there to help me through the pain that I was having at the moment, or at any time. She wasn't there to let me be a kid. She made me grow up to be as teenager when I was only like six, maybe seven…So I really didn't have a childhood. We never had fun when we was kids… my mom was always working, doing something. his mother "not being there for him to help him to deal with his trauma.

Similarly, Ciara described her relational dynamics with her mother as challenging. She reported: "I used to couldn't stand my mom because she used to put everybody else first before her kids…, she put her ex-boyfriend before us." Jaquan described the relationship with his parents to be tumultuous, as his "mom and dad used to be arguing and all that." The parental conflict between both of his parents led to their separation, resulting in "me and my brothers used to go back and forth to my mom house and my dad house." These examples evidence participants' experiences with loss through neglect, abandonment and separation. Perhaps even more clinically noteworthy, they highlight the loss of respect, dignity, hope, innocence (childhood) and "voice" that these youth experience due to their RTF admission, which can mirror the losses associated within the context of their families, communities and society at large (Hardy & Laszloffy, 2005).

5.4.3 How Participants Situate Race

In addition to revealing reflections on tangible and intangible losses, an application of the first element of Narrative theory also reveals that all participants firmly believed that "their behaviors were the primary reason that they were put in the RTF" and not their race. Statements such as "me doing bad things, I started acting worse," "my bad habits, my anger, the way I talk to people, being disrespectful and different stuff," "I used to be defiant. I used to fight a lot in school," support this dominant story of "being bad" and a "menace" to society. Jalecia highlights this belief clearly, by stating:

> I don't think it (me being Black) contributes to me being in here. Being a Black female I just feel okay. I feel like being in here doesn't make it any different because of my race. I feel like I'm still the same. It's nothing really different about it. I see we all the same basically. We act the same and our race don't mean nothing different because we all did something to get in here, I guess.

She further goes on to say, "the majority of us are Black (in here) but it doesn't bother me in any type of way because we not the only people who make dumb decisions. I mean it's all kinds of people. Our race doesn't impact the decision we make." Similarly, when questioned about his experiences as a Black male in the RTF, Jaleel reported, "there's nothing to tell; there's nothing to say about it. That's just my skin complexion. If I was purple, it would make no difference. I don't see no kid getting treated differently, like if I was white or Black." He further clarifies by stating: "want me to tell you what had something to do with me being here? ...Myself, my attitude, my anger, my aggression, my disrespect, that stuff." Nashay's response further supports the notion that some participants had very limited insight into the complexities of their racial backgrounds

contributing to their experiences in being admitted to the RTF. She reported, “I really don’t see no race in here because mostly everybody in here is different races …like Puerto Rican and Indian, like different races like that.”

Despite the participants’ opinions that their “behaviors” were the main reason for their admission to the RTF, the majority of them were able to recognize that Black youth were admitted to the RTF in higher numbers. They described their *views on racial inequalities and injustices* (theme five) they have experienced and observed in society from “being Black.” Deshawn acknowledged that there were more Black and Hispanic youth in the RTF. When asked to elaborate on his understanding of these discrepancies, he stated: “to be honest, I think white people get away with too much. Like that Trayvon Martin death, it was a white person that shot him. He didn’t get charged for it. I see it all the time.” He went on to discuss his own observations of the racial inequalities that exist in the legal justice system, as he compared the experiences of Blacks and whites:

> I seen so many Black people on probation. I know some white people that got probation, but most white people that you come across, they won’t have probation. They won’t even have a charge possibly.

Likewise, Jaquan expressed his views on his experiences in the RTF pertaining to racial differences that he has experienced. He stated:

> Cause I don’t get treated like the whites. Like this white nigga- this white young boy [inserted name] on my unit. He not here, like his family put him here. He get treated different…. He gets treated different by certain people because the young boy gets home passes. His family could take him out whenever they want ‘cause they put him in and I be hatin’ ‘cause I don’t get passes every week.

Here, Jaquan is specifically speaking to the racial discrepancies that exist in the privileges afforded to Black versus white RTF residents. Given that the majority of the participants in this study had some form of system involvement, they were required to get "permission" to go on home passes to visit their families. Conversely, those youth who have no system involvements, like the white youth that Jaquan described, have the autonomy to engage in off-campus activities with their families without restrictions.

On its face, it seems paradoxical that participants were unable to clearly connect how their racial identification may have placed them at higher risk for being placed in residential care. Curiously, when they provided examples of other RTF youths' racial backgrounds, they sometimes identified them as Hispanic or Indian, not white. This apparent multi-layered misunderstanding of what race and racism are, and how they operate socially and personally, might be a consequence of an adolescent lack of socio-political sophistication. It might also be attributed to "internalized racism" and "internalized devaluation" (Hardy, 2013). Internalized devaluation is defined as:

A direct by-product of racism, inextricably linked to the deification of whiteness and the demonization of non-white hues. It is perpetuated throughout society, including in the very systems with the stated mission of serving youth. (Hardy, 2013, p.25)

However, despite the fact that participants failed to appreciate the salience of any internalized devaluation, they *were* able to describe their experiences with racial oppression broadly. Thus, even in the absence of an understanding of the role racism may have played in their RTF admission, the fact that race was present in their narratives *at all* justifies the need to bring these issues to the forefront in family therapy. The meaningful consideration of these issues in RTF therapy may help to provide effective

trauma-informed treatment, which may expedite release and lower the rates of recidivism for Black adolescents.

Also important to note here is the significance of the legal justice system and CPS in placing youth in RTFs. Youth who are adjudicated and/or under the guardianship of CPS have limitations on the course of treatment, specifically in making a collaborative decision on residential treatment. The parents/care givers of these youth are seldom consulted on the best course of treatment for their child(ren). If they are conferred with, they are most often presented with incarceration in a juvenile detention center or admission to a RTF, as the only two options. This speaks to the continued experiences of devaluation even within the different SOC. Sarena highlights the profound differences that she has observed during her treatment in the RTF. She stated:

> So if I see a Black girl walk in this door, I think- oh she either got in a fight, she done stole something or she did that-… but if I see a white girl- oh she's MR, she's mentally retarded. Not like that, but she's here for self-harming, and that's how it is. Sometimes you could be right and something you could be wrong. We don't get too many white people in here that's here for fighting. Only Black people are here for aggression, for drugs, for going through real things and going through a struggle. White people, they got it easy and that's just how it's always going to be…. I'm not saying it's easy for them because they're human too, but by them being white, they got more leeway. It's more like we're stamp. I feel like Black people are judged everywhere, like we're going to be judged no matter where we go.

Descriptions from RTF residents such as Sarena are highly valuable as they provide a clear picture of the challenges that Black youth and families face in this society. They are stereotyped as being "bad and aggressive," which is why "you are being taken away from home (from the community) and placed in a RTF." This message is embedded in them from a very early age, as they become involved in the mental health system. The message is reiterated through successive involvements in different SOC, leading to the eventual removal of the youth from their homes. The experiences of these youth with devaluation are intensified as they are consistently given the message that "because you are unable to function in the world as a law-abiding citizen, you need to be put away," which speaks to their experiences of internalizing the message that they will "make nothing in life." This was evident from Sarena's rather profound statement that their white counterparts are given the "benefit of the doubt" as being "mentally ill/retarded" (Hardy & Qureshi, 2012).

Hardy & Laszloffy (2005) have thoroughly discussed the privileges that exist for white youth, in comparison to Black youth who do not get the benefit of the doubt that they may be victims of trauma, loss, abuse and other factors that lead them to engage in violent inwardly- or outwardly-directed acts. Black youth are often looked at through a lens of criminality, rather than a trauma-informed perspective that should be asking the question *"what has happened to you?,* rather than *"what is wrong with you?"*(Hardy, 2013, p. 25). Despite the mental health system moving towards providing trauma-informed care, it is questionable whether this is the main focus as the SOC are often fragmented and traumatized themselves (Bloom & Farragher, 2013).

5.4.4 Devaluation and Black Youth in the RTF

The findings of this study support the importance of racial complexities that exist in the lives of Black youth residing in the RTF. As intimated above, their experiences are oftentimes culturally specific and embedded in a complex of devaluation that is the result of both situational and societal forces. Situational devaluation includes experiences within interpersonal relationships, such as (childhood) abuse, neglect, abandonment, divorce, and/or peer rejection (Hardy & Laszloffy , 2005). These forces of devaluation can ultimately lead to rage. According to Hardy & Laszloffy (2005) "when rage is suppressed and limited opportunities exist for healthy express, it, like anger, grows and intensifies and the likelihood that suppressed rage will be transformed into violence increases" (p. 96). Indeed, participants in the present study identified working on "their anger" and emotional regulation and management as their treatment goals. Without the appropriate culturally-sensitive therapeutic intervention, the festering of participants' unacknowledged and unmourned trauma may transform into a sustained self-injurious rage that only reinforces anti-social behaviors.

To compound matters, Black youth hold a subjugated position within a marginalized racial group, which creates a context for them to be a target of societal devaluation forces as well. Societal devaluation "involves a generalized sense of being dehumanized because of one's membership in a socially stigmatized and depreciated group" (Hardy & Laszloffy, 2005, p. 47). Groups that hold marginalized positions in society are youth of color, girls, poor and working-class youth, and gay, lesbian and bisexual youth (Hardy & Laszloffy, 2005). The participants of this study held numerous

subjugated positions, which undoubtedly contributed to their experiences with societal devaluation.

For Black youth specifically, experiences with devaluation seldom go acknowledged, as treatment is heavily focused on behavior management and implementing behavioral interventions. The resultant feeling of dehumanization further intensifies their experiences with unrecognized tangible and intangible losses. When the participants were asked about the nature of their therapy session, in reference to addressing socio-cultural trauma, they reported that they "never" or "rarely" discuss these issues in the therapy room. As Jahmir reported:

> Well me being here as Black male doesn't really- I mean most of the population here is Black, so it doesn't feel weird. It feels okay. I'm alright with it. It's kinda interesting. Like with my therapist- I try not to think about race and stuff like that, I don't know, I just try not to think about that being here as a Black African American male, it feels normal. I mean I don't really feel anything, I guess.

It is evident from Jahmir's description that issues around racial oppression are not explicitly addressed in therapy, despite the reality that these youth are thinking about their experiences in a racial context. Instead, Black RTF youth learn early on that these experiences are "normal" because their peers also are involved in the same SOC as them, attesting to the misconception that these experiences are a normal part of life. The normalization of these experiences may be contributing to the internalized messages that their behaviors are the major cause of their removal from their homes and communities, not racial discrimination. This internalized belief makes it difficult for the youth to "identify and name" their experiences with social inequalities, which perpetuates the

cycle of racial oppression and devaluation. The messages surrounding "it's what I did that got me in here (RTF)," is the problem-saturated dominant narrative of their lives, which unfortunately does not leave room for externalizing the problem(s), despite the recognition that there are clear distinctions between the experiences of Black and white adolescents in the RTF. The dominant stories in these participants' lives are embedded with experiences with socio-cultural trauma and loss, exacerbated by the inequalities and injustices they endure because of their racial social location as African American/Black.

5.4.5 Black Youth and Therapeutic Success in the RTF

Theme two, *therapeutic alliance and relationship with RTF therapist* and theme three, *development and cognitive shifts in self*, were both related to the participants' positive experiences in family therapy that initiated some form of therapeutic change. Despite the adversity experienced by the youth through trauma and loss, they appeared to have been a source of resiliency to get them through their treatment. They expressed that they have utilized the RTF admission as a "learning and growing lesson," that has triggered a sense of motivation, eliciting behavioral changes in them through cognitive and development shifts in self. The positive relationship they developed with their respective therapists initiated that process.

All 15 participants highlighted having a "good," "great," "open" relationship with their RTF therapist that mainly stemmed from feeling "heard" and "understood" in sessions. They identified specific behaviors of their therapist, such as "listening," "giving advice," "being helpful," and "being supportive" that contributed to developing a therapeutic alliance with them. As the relationship with their RTF therapist developed over time, the participants reported becoming more receptive to the "advice" that was

being given to them. This ultimately led to developmental and cognitive shifts in how they envisioned their future, in addition to changing their views on family therapy.

The majority of participants described this process of "maturation" as partly the result of the freedom and independence that they lost from being "locked away in the RTF." Their admission to the RTF forced them to think about the realities of their lives and work harder to get back to their families. A large number of participants also indicated their family's involvement in therapy sessions in the RTF encouraged them to work on their treatment goals. The effort that was being made by their family member(s) to participate consistently and frequently in family therapy initiated changes in them. The participants in the study were motivated by the changes seen in their family members as well.

These experiences emphasize the importance of family involvement in therapy in the lives of RTF youth. Despite being taken away from their families, it is imperative that families of these youth remain engaged in the treatment process, as it has shown promising results. Most of the participants described family therapy as being "helpful." Indeed, familial involvement may have contributed to the participants "externalizing" their dominant narratives, allowing them to reconstruct and reauthor alternative stories. Thus, the reauthoring operated to "normalize" the therapeutic process, shifting the participants toward positivity and away from self-blame. One might theorize that engaging others in therapy minimizes the societal label that these youth have taken on as being "bad." Because other individuals are taking part in therapy, youth begin to view it as normal because "everyone has problems" and "it's ok to open up and talk about these problems with someone else."

Indeed, family therapy created room for these youth to express themselves openly, partly because their parent and/or caregiver was able to role-model that behavior for them. As the parent and/or caregiver was able to develop a trusting relationship with the RTF therapist, the youth also began to trust their therapist. The development of the therapeutic alliance allowed for many shifts to take place, not only with the youth, but within the family system as a whole. Other studies also have supported the notion that there is reciprocal linkage between parental and youth behaviors and that parental involvement or lack thereof has a significant impact on treatment (Harr et al., 2013). Overall, the experiences described by the study participants around family engagement further speak to the importance of the influence of parental involvement in family therapy in the RTF for Black adolescents.

5.4.6 Gender and Age in the RTF

Africana womanism and the MCP add to the conceptualization of the participants' experiences in RTF family therapy, as they pertain to age and gender. Africana womanism priorities race as paramount in any deliberations of and about African women (Nitri, 2001). It asserts that the experiences of African people cannot be understood without recognizing the significance of historical realities of Eurocentrism, oppression, and domination, relating to their racially subjugated positions in society (Hudson-Weems, 2001; Nirti, 2001). As with Narrative theory, Africana womanism is undergirded by the social constructivism of the MCP meta-framework, promoting the understanding of one's experiences in relationship to the other, and informing how one views the world both inside and outside of therapy (Hardy & Laszloffy, 2002).

While 73% (11 out of 15) participants were able to provide descriptions of their experiences as it related to their racial backgrounds, only about 27% (4 out of 15) of the participants discussed their experiences in the context of their gender, despite having some difficulty in being able to separate and isolate those experiences as just being a "male" or "female." More so, the researcher was unable to procure an equal number of male and female participants, despite the ratio for females:males in the RTF being 52:43.

The lack of attention paid to Black female RTF residents was particularly evident during the recruitment process, given that the researcher had difficulties identifying female participants for the study. This was mainly because the majority of the female residents in the RTF did not meet criteria for 6 family therapy sessions. Each participant that was identified for the study agreed to participate without any hesitation. There were many youth in the RTF that expressed interest in the study to the Clinical Coordinator, their RTF clinical therapist, and/or even the researcher when they saw her in the hallways. These interested participants did not meet inclusion criteria, which was almost always 6 family therapy sessions first and 6 month LOS in the RTF as the second reason. From this, it is reasonable to conclude that the lack of 6 family therapy session was the primary reason for low rates of female participants in this study.

One could propose two competing hypotheses in attempting to explain the gender disparity in RTF familial involvement. Under an Africana womanist approach, the disparity could be explained by the infiltration of patriarchal values that motivate parents to value males and devalue females. This intra-familial ethic of female devaluation correlates with socially constructed and perpetuated stereotypes of Black females being strong and independent (mammy), angry and outspoken (sapphire), and/or slutty and

promiscuous (jezebel), all of which translate into Black girls not needing and/or deserving protection and support (Watson, 2013). Moreover, the marriage of sexism *and* racism has created a context in which Black girls' devaluation is doubly deleterious to their prosocial development.

On the other hand, there could be a more practical, perhaps culturally specific explanation for the disparity; the high rates of homicide within the Black community may prompt family members to protect their male offspring more than their female counterparts. As discussed previously in this chapter, demographic data compiled by this study regarding male participants and their involvement in acts of physical violence certainly validates this concern. However, whether the enhanced danger to Black males is perceived or actual, it's subjective importance to families and even therapists could indirectly negatively impact the care received by Black girls. Future research should focus on understanding the differences in family therapy experiences for parents, as it relates to their son or daughter being admitted to a RTF. Regardless of the explanation, gender simply was not as salient as other identities in participants' stories.

Age clearly superseded gender in participants' hierarchy of importance. About 47% (7 out of 15) of the participants were able to describe their experiences in family therapy in the RTF as an adolescent. Andre reported that he, at times, felt overlooked in family therapy sessions as a kid: "it's a little hard because the adults look at it on the adult side, but they don't never really pay attention to the kid side…, so sometimes I feel unheard." Aaron further reported that he "feels a little left out because I'm younger and I can't do certain things that adults can do," when he described his experiences in the context of his adolescent age group. Despite feeling left out, he indicated that his RTF

therapist had validated those feelings in sessions with his father, by helping both of them understand each other's perspectives. This is evident by the following statements made by Aaron:

> I could express myself as long as I'm being respectful, but I can't make all the decisions. My dad has to make certain decisions for me because I'm too young. He (my therapist) tells me that I have to understand where my dad is coming from, but then again, he (dad) has to understand where I'm coming from. He just breaks it down to us, I guess.

Moreover, Aaron was able to describe his experiences as a "young" individual to be enlightened as he has learned that "they (adults) are more mature than me and they know more than I do..., they can help me with questions. And they probably been through certain things that I've been through so they can help me with it." This cognitive shift during his adolescent developmental stage has changed the way he and his father interact and relate to one other. Aaron's case is one that shows the complexities in race, gender and age. It is noted that he was participating in family therapy with this father, along with his therapist being a Black male. Despite Aaron minimizing the impact that family therapy has had on his progress, he was able to articulate the positive experiences he has had in family therapy with his father, as his therapist has been able to create a safe place for both males to have open dialogues about the challenges in their relationship.

All in all, when participants discussed their experiences in the context of their social locations they were able to provide descriptions relating to both inside and outside of the facility, with race being the primary context of their experiences. The participants discussed their experiences with racial injustices and injustices, which led to their

involvement in different SOC. The quotes presented in this chapter and Chapter 4 provides support for the notion that the participants' experiences in family therapy in the RTF were formed through their cultural identities, in their various dimensions. These cultural dimensions of race, gender, class and age have informed their views of self in relationship to other groups (Hardy & Laszloffy, 2002; Hudson-Weems, 2001; Nirti, 2001).

5.5 Clinical Implications

There are several clinical implications that can be derived from this study. Black adolescents are admitted to RTFs at high rates. Black youth are involved in different SOC, which increases the likelihood that they have experienced trauma, loss and devaluation within the context of their families and communities. However, issues regarding trauma, loss and devaluation are rarely addressed in the therapeutic interventions that are being utilized in RTF therapy. This was evident from the participants' response when they were questioned about "whether issues of race were being discussed in family therapy." They reported "no we don't talk about race like that," in addition to some stating "race does not matter."

Others provided clear descriptions on their views of the racial inequalities and injustices that they have experienced in their lives. They also compared the experiences of their white adolescent counterparts, who are treated differently (better), just on the mere basis on their skin color. The participants' experiences with "being Black" have placed them a marginalized group that is degraded and devalued on various levels. This suggests the need to alter the therapeutic interventions being utilized for Black RTF residents to incorporate and address issues of socio-cultural trauma.

There were also two significant findings regarding the nature of the client-therapist relationship. First, the fact that both male and female participants felt comfortable with a female therapist raises important clinical questions, specifically about gender socialization. Is this because males feel they can be more emotionally vulnerable with a female therapist, but feel the need to be "tough" and "macho" with a male? Are there professional tools and techniques that a male therapist could learn from a female therapist to enhance his ability as a RTF therapist and optimize therapeutic outcomes?

Second, most participants stated that the race of their therapist was unimportant, perhaps underscoring the centrality of the therapeutic relationship itself in achieving therapeutic goals. From a clinical perspective, the finding re-emphasizes the need for a therapeutic approach such as VCR (validate, challenge, request), which allows for participants' experiences with trauma, loss and devaluation to be acknowledged (validating), while simultaneously challenging and requesting that needed behavioral changes take place. With that being said, it is important to ensure that successful outcomes are, in fact, a result of the therapeutic process, and not a result of exogenous factors such as participants "faking" success to stem the losses that are socially incurred from placement in the RTF. Approaches like VCR, which encompass the cultural complexity of the trauma and loss experiences by Black youths, are also indispensable in ensuring that therapeutic outcomes are durable, lasting and recidivism-resistant. Fortunately, it appears that the RTF therapists may have been employing the VCR approach in therapy without the knowledge of the technique itself.

Further trainings on socio-cultural trauma could assist in bringing these issues to the forefront. However, it is particularly noteworthy that, although fewer than half of the

therapists in the study were trained family therapists, positive outcomes were overwhelmingly reported. This finding is supported by established social science literature which underscores the importance of the therapeutic alliance, an importance which may supersede that of formal training in achieving therapeutic goals. Therapists providing services to Black families should become familiar with the cultural intricacies underlying their trauma, as it may help lower rates of recidivism of Black youth. Because socio-cultural trauma is not often addressed in therapy, it may explain the high rates of the study participants' involvements in numerous SOC. Ultimately, conversations on societal injustices, as they relate to one's subjugated social locations, must enter the therapy room if long-term behavioral changes are to be sustained.

5.6 Study Limitations

There were several limitations to this study. First, the researcher excluded interviews with family members and/or caregivers who were participating in family therapy with the youth. It is important to gain their perspectives as well, specifically from a qualitative inquiry. Future research should focus on the experiences of both the youth and other family members who are participating in family therapy in an RTF. By interviewing all parties who are involved in RTF family therapy, researchers can provide another perspective on other individuals' experiences with the phenomenon. A study comparing the achievement and durability of pro-social treatment outcomes for youth with familial involvement to those without familial involvement could be especially useful.

Second, other males and females who self-identified as non-Black were excluded from participating in this research study. As the experiences of males and females are

unique and different, studying various adolescent racial groups will assist in gaining a broader sense of gender-specific differences in the RTF adolescent population. Third, inclusion of younger and older youth may bring an entirely new perspective to the research phenomenon. Understanding the experiences of children in different age groups may benefit the field of mental health in providing specialized care that is age-appropriate and effective. Fourth, youth who self-identified as transgender or transsexual were excluded and their experiences may enhance therapeutic knowledge and effective treatment. Fifth, children who presented with severe cognitive limitation and/or mental retardation also were excluded from the study. It would be very important to understand how family therapy is conducted and provided with this specific population, due to their limitations.

Sixth, the researcher's privileged positions as a middle-class, educated female, attending a prestigious university, can be noted as a limitation that may have impeded on building trust and rapport with the participants. These differences may have deterred the participants from openly discussing their experiences in family therapy in the RTF because they may have been operating under the assumption that the researcher could not "understand" their perspectives and/or experiences. The researcher may have been perceived as "other," who is part of the "system that put them away," hence she cannot be "trusted." This perception could have easily influenced the participants' honest disclosure of their experiences to the researcher, leading to inaccurate details. Along the same line, some of the participants reported they were "fakin it to make it," calling into question whether they were "fakin it" during the interview and providing answers that they "thought" the researcher wanted to hear.

Likewise, the race and gender of the researcher may have been a limitation to the study, altering the study results. Given that the majority of the participants in the study were males, the participants may have not been able to connect with the female researcher. Additionally, despite the researcher identifying as a person of color, not Black and/or African American, racial differences may have impeded on the results of this study. An additional limitation of the study is the lack of applicability of the results to other RTFs, as the participants were recruited from one facility only. Also, the results cannot be generalized to the RTF population in different geographical locations and areas. The small sample size of 15 participants was another limitation of this research study.

There were also several, more ancillary limitations to the study. The interview questions could have been clarified and expanded to eliminate confusion on the part of the interviewees and to dig deeper into the phenomena under study. Deeper, more authentic interview responses may also be evoked through strategically implemented, culturally appropriate group activities or videos. Additional insight may have been gained if the researcher had participated in some group therapy sessions with the clinical therapists to experience discussions of trauma, cultural diversity and family systems firsthand. The proper management of these limitations may have alleviated certain discomfort the study participants may have experienced, particularly when they were asked questions that pertained to serious subject matters.

5.7 Suggestions for Future Research

In examining previous research on residential treatment programs, the literature is scarce on addressing the experiences and needs of Black youth and their families.

Previous studies that have been conducted on residential treatment programs have focused primarily on collecting quantitative data on various needs of the youth population and outcomes upon discharge. Moreover, much of that data has been collected from the perspectives of other people, such as treatment providers, therapists, teachers, and/or parent(s) and/or caregiver(s) who disclosed information on the behavioral changes and emotional stability of the youth. There has been very limited qualitative research data collected that has focused on creating a safe space for the youth to tell their stories of their experiences in the therapy room.

The findings of this study suggest that further studies need to focus on understanding the experiences of all family members engaging in family therapy in RTFs. These experiences also deserve a qualitative lens, so that the participants have the opportunity to openly discuss their experiences in therapy. It would be imperative to engage the parents and/or caregivers of Black youth who participate in these family therapy sessions in future research studies. Only they will be able to shed light on their experiences on their views of family therapy and the shifts that have (or have not) taken place for them in family therapy in RTFs. They will be able to describe their own limitations and challenges concerning the working of different SOC that are involved in the care of the adolescents. Engaging parents in research will provide therapists a systemic view of some of the barriers and strengths in providing treatment in RTFs.

Future research also should proactively seek an equal number of both male and female participants, so that gender differences can be fully examined and deconstructed to understand the clinical needs of the RTF population. It might also be important to determine whether the sex of the therapist matters (i.e., do female participants prefer

female therapists?), both in the comfort level of the participants as well as the type of responses given to interview questions. Similarly, future research could determine the role of therapist training (i.e., prevalence of culturally competent training, knowledge of sociocultural impacts of trauma, experiences of non-trained family therapists) in RTF family therapy outcomes. Lastly, comparison studies on racial, gender, and economic differences also should be acknowledged in future studies within the RTF youth population.

5.8 Conclusion

This study makes a significant contribution to the field of Couple and Family Therapy (CFT) because it provides insight into Black youth's experiences in family therapy in an RTF. The study's participants were able to describe their experiences in family therapy in the RTF solely from their perspectives. The researcher opened up a previously closed avenue of research for mental health professionals to understand the experiences of the lower-income Black adolescent residential population, as it pertains to family therapy in a RTF. The findings of this study contributed substantive data to an area that has been minimally studied. Stated succinctly, this study added depth and nuance to the dearth of information that currently exists with the Black RTF youth population.

The fifteen participants that took part in this research provided great insight into their experiences in family therapy in an RTF. They described their experiences in family therapy in the RTF as having a positive influence on their familial relationships. Their RTF therapists created an opportunity for them to resolve family conflict that once impeded on their ability to communicate more openly with their parents and/or

caregivers. Despite the challenges they have faced within the different SOC, they utilized family therapy as a means to improve their family life, and to make positive changes in themselves that will help them achieve their goals in life.

The findings also suggest that the RTF therapists developed close therapeutic relationships with these youth, which assisted in achieving the goals of "getting out of the system." Overall, the participants provided data on the RTF issues that exist in different social contexts, such as race, gender, class and age. However, they showed limited insight into the injustices that perpetrate the cycle social inequality, an inability which may have resulted from their experiences with devaluation in different socio-cultural contexts. The tripartite lenses of Narrative theory, MCP and Africana Womanism were used both individually and in combination to contextualize participants' experiences with trauma, loss and devaluation, as explanations for admission to the RTF and as therapeutic tools that can facilitate participants release from the RTF.

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APPENDIX A: DEMOGRAPHIC SURVEY

Participant Initials_____

Date_____

Please answer the following questions.

1) Demographics Information:

a. Age:

b. Class/SES:

c. Religion:

d: Sexual Orientation:

2) Reason(s) for Admission:

3) Length of Stay at Facility:

a. Admission date:

b. Length of Stay:

4) Family Therapy Sessions:

a. # of sessions:

b. Person(s) attending FT:

5) # of Prior Admissions to RTFs:

6) Legal Involvement:

a. Age of first contact:

b. Reasons/Charges:

7) DHS/CPS Involvement:

a. Age of first contact:

b. Reason(s):

9) Previous Hx of MH Treatment:

a. Age of First Contact:

b. Types of services:

1.Outpatient:

2.Intensive Outpatient Programs:

3.Partial Programs:

4.Inpatient Hospitalizations:

10) Diagnosis (Diagnoses) Given:

APPENDIX B: INTERVIEW GUIDE

Research Question: How do Black adolescents in a RTF describe their experiences in family therapy?

Interview Sampling Questions

1. **Describe your experiences in therapy in the RTF.**
a. What is your understanding of therapy in the RTF?
b. How often are you meeting with your therapist in the RTF?
c. How would you describe your experience in therapy in the RTF in comparison to therapy elsewhere?
d. How would you describe your relationship with your therapist in the RTF?
e. Do you feel that your therapist understands you in therapy in the RTF?
f. What has been helpful for you in therapy in the RTF?
g. What has not been helpful for you in therapy in the RTF?

2. **Describe your experiences in family therapy in the RTF.**
a. Who has been attending family therapy with you in the RTF?
b. How often are family therapy sessions taking place in the RTF?
c. What is your understanding of family therapy in the RTF?
d. How would you describe the relationship your therapist has with you **and** the person attending family therapy with you in the RTF?
e. Do you feel that your therapist understands you during family therapy sessions in the RTF?
f. What has been helpful for you in family therapy in the RTF?
g. What has not helpful for you in family therapy in the RTF?

3. **Describe your experiences in family therapy as a female/male residing in the RTF.**
a. What are your experiences as a female/male in the RTF?
b. What are your experiences as a female/male in family therapy in the RTF?
c. How you do think your gender influences your experiences in family therapy in the RTF?
d. Do you feel that your therapist understands your experiences as a male/female in family therapy in the RTF?

4. **Describe your experiences in family therapy as a Black female/male residing in the RTF.**
a. What are your experiences as a Black female/male in the RTF?
b. How do you think you race influences your experiences in the RTF?
c. What are your experiences as a Black female/male in family therapy in the RTF?
d. How do you think your race influences your experiences in family therapy in the RTF?

e. Do you feel that your therapist understands your experiences as a Black male/female in family therapy sessions in the RTF?

5. Describe your experiences in family therapy as an adolescent in the RTF.

a. What are your experiences as an adolescent in the RTF?
b. What are your experiences as an adolescent in family therapy in the RTF?
c. How you do think your age influences your experiences in family therapy in the RTF?
d. Do you feel that your therapist understands your experiences as an adolescent in family therapy in the RTF?

6. Describe your experiences in family therapy in terms of your socio-economic status (SES) in the RTF.

a. How do you describe yourself in terms of your SES?
b. What are your experiences as a **(SES fill in)** person in the RTF?
c. What are your experiences as a **(SES fill in)** person in family therapy in the RTF?
d. How you do think your SES influences your experiences in family therapy in the RTF?
e. Do you feel that your therapist understands your experiences as a **(SES fill in)** person in family therapy in the RTF?

APPENDIX C: RECRUITER FLYER

VOLUNTEERS NEEDED FOR RESEARCH STUDY ON FAMILY THERAPY IN A RESIDENTIAL TREATMENT FACILITY

- ☑ **Are you 15 or 16 years old?**
- ☑ **Do you self-identify as Black AND African American?**
- ☑ **Have you resided in the residential treatment facility for at least six months?**
- ☑ **Have you participated in at least six family therapy sessions?**
- ☑ **Are you able to contribute two hours of your time for a one-on-one interview (two parts- one hour each) on your experiences in family therapy in the residential treatment facility?**

- **If you meet ALL of the above criteria, you may be eligible to participate in a research study on the experiences of Black adolescents in family therapy in a residential treatment facility.**
- **The purpose of this study is to understand the experiences of Black adolescents (males and females), in family therapy in a residential treatment facility.**

Participants will receive $25 upon completion of study

For more information contact: **Misbha E. Qureshi, MFT**, **Doctoral Candidate**
Phone #: **267-766-2000 x4637**
Email: familytherapyRTFstudy@gmail.com

This research is conducted by a researcher who is a member of Drexel University. It has been approved by the Drexel Institutional Review Board.

APPENDIX D: CURRICULUM VITA

MISBHA E. QURESHI, PhD, MFT, LPC

EDUCATION

Drexel University Philadelphia, PA
College of Nursing and Health Sciences
Doctor of Philosophy, Couple & Family Therapy (CFT) Sept 2010-March 2017
Honors: Academic Excellence, 4.0, Spring 2011 & Spring 2012
Cumulative GPA, 3.8

Master of Family Therapy (MFT) Sept 2007-June 2009
Honors: Academic Excellence, 4.0, Winter 2008
Cumulative GPA, 3.8

University of Maryland College Park, MD
School of Public Health
Bachelor of Science, Family Studies Aug 2002-Dec 2006

College of Behavioral and Social Sciences
Bachelor of Arts, Criminology & Criminal Justice Aug 2002-Dec 2006

TEACHING EXPERIENCE

Philadelphia University **Philadelphia, PA**
Adjunct Faculty Spring 2016
- Taught two sections of Crisis Prevention/Intervention Strategies course in the Master of Science in Community and Trauma Counseling Program

Camden County College **Blackwood, NJ**
Adjunct Faculty Spring 2014
- Taught Treatment and Assessment of Addiction II course in the Human Services Department

Drexel University **Philadelphia, PA**
Graduate Assistant Spring 2011
- Taught Addictions in the Family graduate course in the Couple and Family Therapy Program

PUBLICATIONS

Hardy, K. V. & Qureshi, M. E. (2012). Devaluation, loss, & rage: A postscript to urban African-American youth with substance abuse. *Alcoholism Treatment Quarterly, 30 (3)*, 326-342.

Mendez, N.A., **Qureshi, M. E.**, Hort, F., & Carneiro, R. (2014). The intersection of facebook and structural family therapy volume 1. *The American Journal of Family Therapy, 42 (2),* 167+-174.

Qureshi, M. E., Apolinar Claudio, F. L., & Mendez, N. A. (2015). The intersection of social media sites and narrative therapy in treating substance abuse in urban African American adolescents. *Alcoholism Treatment Quarterly, 33 (2).*

PRESENTATIONS

National Association of Mental Illness (NAMI), Annual Conference **Towson, MD**
October 2016

- Understanding the Experiences of Lower-Income Black Adolescents in Family Therapy in a Residential Treatment Facility (RTF): A Multicultural Perspective

The Muslim Community Center **Silver Spring, MD**
April 2015

- Mental Health and Muslims in the United States: Who Are We?

The Multicultural Family Institute, Annual Cultural Conference **Piscataway, NJ**
April 2014

- Transforming Life Narratives: Weaving Stories of Healing (*Roundtable Discussion-Facilitator)*
April 2013
- The Search for Home: Legacies of the Diaspora- Clinical Implications (*Panelist*)

International Family Therapy Association, Annual Conference **Orlando, FL**
February 2013

- Family Therapy along the Margins & in the Trenches: Tips, Tools, & Tricks of the Trade

Drexel University
Philadelphia, PA

- *Lindy Center for Civic Engagement* May 2012
  Understanding Prejudice, Discrimination, Stereotypes, and Oppression
- *Office of Equality and Diversity* March 2012
  Diversity of Appearance among Women
- *Couple and Family Therapy Department* January 2012
  Addiction in Families
- *Office of Multicultural Programs- Social Justice Week* January 2012
  Bringing Social Equality: Voices of the Subjugated

NJ Association for Multicultural Counseling, Annual Conference **West Windsor, NJ**
October 2011

- The Forgotten Families: Impact of Suicide on Family Members of the LGBT Population

MANAGEMENT EXPERIENCE

Wordsworth Academy
Philadelphia, PA
Clinical Coordinator- BHRS
Dec 2015- present

- Responsible for ensuring the overall clinical and administrative oversight of the direct service employees, to include Behavioral Specialist Consultant (BSC), Mobile Therapist (MT), Lead Clinician (LC), Therapeutic Staff Support (TSS) in the *Behavioral Health Rehabilitation Services* (BHRS) program
- Work in collaboration with the assigned module Psychologist, Case Coordinator and Payroll Processor to ensure adherence to regulatory policies/procedures and attainment of program/module goals
- Assign, monitor, and supervise BSC/MT/LC staff to new cases that are appropriate to their clinical experience, schedule, and location in the community
- Provide clinical supervision to BSC/MT/LCs to ensure that effective therapeutic services are being provided to clients and families
- Conduct monthly group and individual supervision to oversee administrative and clinical responsibilities

- Track, monitor, review, and approve treatment plans to ensure quality, timeliness, compliance with format and consistency with evaluation, and clinical relevance to assigned cases
- Troubleshoot concerns that arise from parents, BSC/MT/LCs, third parties, and CBH agency administration
- Track and monitor status of cases on the assigned module to insure that authorizations are current
- Work with module psychologist to provide clinical leadership to staff and manage crises
- Coordinate with training department to conduct clinical trainings in areas of particular expertise
- Assist Case Coordinator with staffing needs of TSS workers

Oaks Integrated Care
Mount Holly, NJ
Crisis Supervisor- CRC
March 2011- Sept 2012

- Responsible for the efficient day-to-day functioning of two crisis response centers (CRC; *Kennedy Memorial Hospital*-Cherry Hill, NJ and *Our Lady of Lourdes Medical Center*- Camden, NJ)
- Provided exceptional psycho-educational services on various topics – anger management, domestic violence, drug and alcohol abuse, child development, women's sexual health, parenting/family planning, and eating disorders
- Completed clinical psychiatric and substance abuse evaluations to determine appropriate level of care (LOC)
- Provided on-site monthly clinical supervision and training to crisis staff
- Coordinated staff meetings and scheduling for coverage on both crisis units and outreach
- Served as a liaison between behavioral health clinicians, psychiatrists, and hospital staff
- Assisted staff with case dispositions and community linkages
- Provided extensive training to new staff (including crisis counselors and managers)
- Completed thorough intake evaluations - BioPsychoSocial (BPS) assessments, billing, progress notes (SOAP/DAP), discharge summaries, and aftercare/recovery plans
- Thoroughly reviewed client records/charts and accurately complete incident reports

CLINICAL EXPERIENCE

Wordsworth Academy
Philadelphia, PA
Clinical Therapist- APHP
June 2014-Dec 2015

- Provided short-term, solution-focused individual, family, and group therapies to assigned client caseloads in the *acute partial hospitalization program* (APHP)
- Provided therapeutic intervention and consultative support to behavioral health workers (BHWs) during crises
- Completed all required documentation in the behavioral electronic clinical record (Credible) to meet agency and state guidelines
- Completed utilization reviews every five days with CBH representative
- Worked as a liaison between family members and outside agencies in evaluating treatment plan goals
- Provided case management services to ensure effective coordination between all involved parties and stakeholders
- Coordinated discharge planning services/after-care plans that were clinically appropriate for continuity of care
- Scheduled and lead interagency meetings with APHP treatment team and outside providers

- Actively attended and participated in ongoing monthly staff meetings, supervisions and on-site/off-site trainings
- Provided clinical supervision/oversight to master level social work interns
- Discussed appropriate clinical interventions during case reviews in monthly group supervision with team members
- Co-facilitated group supervisions by providing clinical training on different topic areas (such as family therapy intervention models, techniques for therapeutic engagement, etc.)

Clinical Therapist- RTF
Sept 2012-June 2014

- Provided clinically appropriate individual, family, couples and group therapy for each assigned caseload in the *residential treatment program* (RTF)
- Provided crisis intervention as necessary including consultative support to direct care staff
- Demonstrated use and supported of the *Sanctuary Model* in all aspects of employment, including interactions with clients/students, family members, other employees, community members, and stakeholders
- Completed all required documentation, related paperwork, in accordance with licensing standards and agency policies
- Provided timely, accurate and complete reports for internal and external purposes
- Worked as a liaison between family members, outside agencies to communicate and evaluate treatment impact and issues
- Worked closely with case management staff to support effective coordination and coordination with all involved parties and stakeholders
- Verified funding acquisition and continuation of aftercare/discharge planning and services
- Actively participated in ongoing clinical supervision to provide the best possible therapeutic services
- Attended and participated in required meetings, supervisions and training programs, demonstrating growth in learning

Oaks Integrated Care
Mount Holly, NJ
Crisis Counselor/Screener
June 2009-present

- Provide therapeutic crisis intervention services to adults, adolescents, families, couples and children experiencing psychiatric illness, emotional/behavioral disturbances, and addiction problems
- Conduct crisis psychiatric and substance abuse evaluations to determine appropriate level of care (LOC) on an inpatient crisis/psychiatric unit and in the community
- Provide brief individual and family counseling/therapy to adults and children
- Make appropriate psychiatric and/or substance abuse community referrals/linkages for clients and families
- Maintain proper medical records and discharge planning
- Conduct daily utilization reviews with managed care providers, including private insurance, Community Behavioral Health (CBH), and managed Medicaid
- Work collaboratively with outside agencies
- Provide case management and crisis planning services

Dunbar Community Counseling Services (DCCS)
Philadelphia, PA
Outpatient Therapist
Jan 2015-Sept 2015

- Provided appropriate therapeutic services, including individual, couple, and family therapy to children, adolescents, and adults
- Completed comprehensive psychiatric and/or psychological evaluations to determine appropriate level of care
- Maintained proper client records in accordance to CBH requirements
- Developed comprehensive individualized treatment plans that were goal-orientated, measurable, and attainable
- Collaborated with outside third parties to determine and implement appropriate interventions

Citizens Acting Together Can Help Inc. (CATCH)
Philadelphia, PA
Outpatient Therapist
Sept 2009-Aug 2010

- Completed comprehensive evaluations to determine proper modality of treatment
- Developed initial treatment plans for assigned client load
- Provided appropriate therapeutic services, including individual, couple, family, and group therapy
- Maintained proper client records in accordance to CBH requirements
- Developed comprehensive individualized treatment plans that are goal-orientated, measurable, and attainable

CERTIFICATIONS

State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors
Licensed Professional Counselor (LPC; License # PC009024; Expires 02/28/19)
Marriage and Family Therapist (MFT) Licensure Candidate
Research Foundation for Mental Hygiene, Incorporated
Columbia Suicide Scale Certificate
Behavioral Health Training and Education Network
Trauma-Focused Cognitive Behavioral Therapy Certificate
QPRT Suicide Risk Assessment and Training
Question, Persuade, Refer, Treat/Triage (QPRT) Certificate
Crisis Prevention Institute
Nonviolent Crisis Intervention Certificate
NJ Department of Human Services- Division of Mental Health
NJ Screener Certification: S-4462 (Expires 12/31/17)
Oaks Integrated Care/Wordsworth
CPR & First Aid

SKILLS

Language: Urdu/Punjabi (Fluency), Arabic (reading proficiency), Hindi (listening proficiency)

Computer: Microsoft Office (Excel, Word, Power Point)

REFERENCES

Furnished upon request